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ABSTRACT

Six papers examine aspects of special education and rehabilitation of developmentally handicapped persons. The first, "Legal and Human Rights of the Developmentally Handicapped Person" by N. Marlett examines issues in the protection of legal rights and the nature of competence. R. Davies and P. Johnson follow with an analysis of "Sexuality and the Person with a Mental Handicap." M. Clark reviews recent trends and notes approaches to assessing skills and training new ones in "Recreation and Leisure Services for Handicapped Persons: Changing Staff Roles." In the fourth paper, "Programme and Management Issues in the Development of Habilitation Programmes" R. Brown addresses such questions as selection of a broad or advisory committee, cost effectiveness, and program integration. P. Johnson considers "The Role of the Voluntary Society in Canada," noting similarities between services in Vancouver, Canada and England, and citing the positive effects of vigorous advocacy efforts. In the final paper, R. Brown examines "Future Trends in the Rehabilitation of Developmentally Handicapped Adults: Progress and Problems," highlighting the impact of such factors as integrated programs, multidisciplinary involvement, and normalization. (CL)

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WESSEX STUDIES IN SPECIAL EDUCATION

4

1985

Editor:

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LEGAL AND HUMAN RIGHTS OF THE DEVELOPMENTALLY HANDICAPPED PERSON

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The 1983 revisions to the Mental Health Act in England and Wales may well be considered as landmark legislation for mentally retarded persons and the elderly because of the impetus created by the exclusion of these two groups from guardianship legislation. Historically guardianship in this country has focussed on the process of ensuring protective care for persons considered incompetent because of mental health problems. In recent years this legislation has been used to extend protective services such as standards of care, due process and legalized substitute decision-making to mentally retarded and confused elderly persons living in community settings but in need of protective services.

However, in order to achieve such safeguards these persons were erroneously labelled as mentally ill. This same dilemma was faced by Canadians, specifically Albertans, when, in 1972, mentally retarded persons were excluded from the Provincial Mental Health Legislation. A situation suddenly arose which left no due processes in place to detain persons in institutions who might be of danger to themselves because of lack of cognitive ability. This institutional crisis highlighted society's need to ensure that persons in all types of care facilities received treatment and care in the least restrictive manner possible and in a way which recognized dignity, promoted growth and the maintenance of independent skills.Whilst persons in care represented the tip of the iceberg, this led to discussion of issues involving all vulnerable adults - ie, persons over eighteen and therefore legally considered able to make their own decisions but yet incapable of doing so.

Before the 1950s mental retardation was synonymous with incompetence and therefore procedures for establishing competence were much simpler. Clarke and Clarke (1954), for example, summarized the perceptions of the mentally retarded in scientific literature as follows: incapable of adapting themselves to anything out of the ordinary and only capable of the simplest routine tasks under constant supervision. This perspective of permanent incapacity changed in the 1950s when research showed that, when learning principles were systematically applied, the mentally retarded were capable of learning and performing manual tasks close to normal expectations,(Clarke and Hermelin,1955). Not only were retarded persons able to perform complex manual tasks but their intellectual growth followed the same developmental stages as the normal child, albeit at a slower pace,(Woodward,1971).

The acceptance of the principle of normalization (Nirje,1969;Wolfensberger,1972)and the subsequent development of service delivery alternatives - family support, community residences, integrated schooling, workshops and protected employment provided many opportunities for the mentally retarded to learn new skills. The development of specialized vocational rehabilitation methods has shown that competitive vocational skills are within the range of not only the mildly and moderately handicapped but of the severely handicapped as

well,(Gold, 1973; Bellamy, Peterson & Close, 1975; Brown & Hughson, 1975; Martin & Flener, 1976).Significant advances have also been made in the residential and recreational domains, (Wehman et al, 1976; Beck, Brown & Possberg, 1977; Marlett, 1979).

Similar trends can be noted with the aged. As decreasing competence was seen as an inevitable result of aging, institutionalization was accepted as the only alternative to providing care. This has changed dramatically with the realisation that institutionalization usually accelerates the loss of independence. Bair and Leland (in Hillman and Libro, 1966) state that the institutionalized mentally retarded aged more rapidly than other individuals. Recent trends in home services and support are proving to be superior to institutionalization in maintaining independence.

As persons who have been isolated are allowed greater opportunities to become involved in the full spectrum of community life, new challenges arise. While training technologies have provided the means to teach many skills to live and work within society, the mentally retarded and the confused elderly are increasingly exposed to subtle and often ambiguous situations within the community that they have not been trained to handle. Decision-making, assertion and social discrimination are just now being addressed as targets for training, (Kivitz,1973; Ryba, 1976; and Crawley, 1983). There is a need for protective support services which will allow persons who may be at risk to maintain their place within society by providing a back-up resource, in essence, a safety net in situations where their human rights are challenged.

When are substitute decisions required?

We have made the commitment to developing methods of teaching handicapped persons to handle the complexities of modern community life. We must now take steps to ensure that the legal rights of those who are vulnerable because of their mental status are protected as they take their place within our society. The following legal rights and legal definitions of competence are particularly important.

LEGAL RIGHTS

1. The right to give informed consent.

'Consent' protects the right of self determination to undergo or forego treatment (eg. medication, health care, aversive therapies, etc.). It also provides legal coverage for those offering the services. In fact, English law clearly states that a patient may only be treated with his consent, or being an infant (up to sixteen) with consent of parents (Family Law Reform Act 1969, Sec.8). Doctors may risk an action for trespass of the person except in medical emergency, (Edwards, 1976). Persons who are informally admitted to psychiatric settings are considered

able to consent to treatment despite their impaired mental capacity.

The need to validate a person's ability to give informed consent, or to provide alternative mechanisms to informed consent has been a major impetus for enactment of guardianship legislation. Dr. Loren Roth (1977), as part of a major research study into legal and medical issues of consent, has dealt with the following legal/medical tests of competency.

(a) Evidencing a choice: This test is set at a very low level and is most respectful of the autonomy of patient decision-making. Criteria of competence relates to the presence or absence of choice, not the quality of the choice. This test of competence is the easiest to measure. In English law it was assumed by the Medical Treatment Act 1930, that if the patient was capable of signing the form and understanding its significance, he was able to give informed consent.

(b) 'Reasonable' outcome of choice: This test entails evaluating the patient's capacity to reach a 'responsible' decision, (ie, the emphasis is on outcome, not on the decision or how it was reached). This is the test most often used when clear guidelines are not available. Because criteria for evaluation often depend on the values of the evaluators, inconsistencies can arise. Cultural or religious differences are the most common sources of conflict here, (eg, white, protestant, middle-class values are assumed to be reasonable, all others unreasonable).

(c) Choice based on 'rational' reasons: This test relates to the quality of the patient's thinking. The question that arises is whether his decision is due to, or the product of, mental illness? Roth has advocated against the use of this test because it is conceptually and legally unsound, and it can too easily become a global indictment of the competence of mentally disabled persons. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency observed: "It is recognised that unsoundness of mind does not necessarily affect all faculties and is not necessarily completely disabling". (1957. Cmnd. 169)

(d) Ability to understand: The ability to understand the risks, benefits and alternatives is the test that is most consistent with the law of informed consent, and is basically the definition adopted by McLaughlin (1979). Decision-making need not be rational in either process or outcome, but the person must demonstrate sufficient ability to understand the information. A major problem with this test has been the reliance on unobservable and inferential mental processes rather than on concrete and observable elements of behaviour.

2. The right to use the courts

Rights and privileges are meaningless unless they are complemented by an ability to enforce these rights. In order to be considered capable of standing trial, the person must be able to understand the proceedings at the trial so as to make proper defence, to be able to challenge a juror, and to understand the evidence presented, [Criminal Procedures (Insanity) Act 1964, s.4]. In order to be considered able to bring suit to recover damages, the mentally handicapped person must be able to explain the nature of his injuries and the facts surrounding the incident, and must be able to withstand cross-examination in court. Tests of capacity to stand trial, initiate action, secure defence, or bring evidence are determined within the context of the case except in situations where, by reasons of insanity, the individual is considered mentally incompetent in all matters.

3. The right to contract

A contract, a legally binding promise, is an essential part of commercial and financial transactions such as agreements to purchase, to lease, to provide service, etc. Anyone may enter a contract if he or she has the capacity to understand the nature of the promise made and the obligations arising out of it. Mentally retarded persons are not, by law, considered incapable of entering a contract. Consumer's legislation (Sale of Goods Act, 1977) outlines unfair trade practices which include taking undue advantage of a person who is obviously not capable of understanding. There are no rules or precedents to use in determining when the courts will set aside a contract on the basis of contractual incapacity. Instead, courts generally weigh all of the facts of the particular case and will support a contract even if the person is mentally deficient, if it can be demonstrated that he had sufficient capacity to comprehend the nature and consequences of the particular agreement.

Each of the above rights has exclusion clauses based on the competence of the person in the particular context. If the mentally retarded are to gain permanent access to these and other legal rights, it is important that there be a positive assumption of the competence of the mentally retarded, the aged, etc. When there are reasonable doubts as to competence, there should be clear and objective guidelines as to how to assess competence in that context.

Predetermination of competence prior to the event presents serious problems. Ability to give informed consent, to give evidence, or to contract, is determined largely by the individual's experience or exposure to that situation; thus, until the situation arises, it is almost impossible to determine whether the individual, given the circumstances and adequate training, could be considered competent or incompetent.

Daily decisions based on legal and human rights

1. Living arrangements

The choice of an appropriate group home, or the possibility of temporary admission to an institution are all decisions that need careful attention for the person who is unable to evaluate his present situation, or is unaware of the alternatives available or the supports needed. The need for a substitute decision-maker is most apparent when the disabled or elderly adult has been institutionalized for a long period of time, where there has been family neglect, abuse or excessive overprotection or when a person begins to seriously neglect himself.

2. Programme decisions

This is often combined with decisions relating to work. However, while many disabled adults require assistance in speaking for themselves in a potentially exploitative work situation (wages, insurance, conditions of work, etc.), it is inconsistent to label a prospective employee as incapable of handling his own affairs yet capable of being competitively employed.

The category of programme/training decisions also includes educational and vocational training and various therapies (eg, physiotherapy, speech therapy, and behaviour modification programmes). A substitute decision-maker may be useful in a situation where the dependent adult is unable to gain access to an educational or specific treatment programme. A substitute decision-maker may also be necessary when the dependent adult does not understand the purposes of the training/treatment or is unable to evaluate either his or her present situation or his or her alternatives, (eg, he may be required to give consent to behavioural control measures). While the person may understand a behavioural system and, in fact, may use the system to personal advantage (eg, breaking rules just before 'graduation' in order to remain), the overwhelming effect of exposure to a behaviour control programme is loss of personal control. Behaviour control programmes are intended to suppress deviant behaviour but in so doing they also suppress independent thinking and the ability to make decisions about the rules themselves. Assertion and self-control programmes are emerging to address this problem, (Mahoney & Thoresen, 1974).

Numerous authors have addressed the issue of informed consent as it relates to treatment. To be considered valid, consent must be voluntary, knowledgeable, and competent (Kaimowitz v. Michigan Department of Mental Health, 1973; Wyatt v. Aderholt, 1974; Turnbull, 1977). Voluntary consent assumes an exercise of free will and clearly precludes the existence of overt coercion and force. It is difficult to determine the voluntary nature of consent where coercion is implied because of the dependent situation of the individual and the lack of realistic alternatives. Implied coercion overrules a written

consent;

> "Involuntarily confined mental patients live in an inherently coercive environment where indirect and subtle psychological coercion has profound effects upon the patient population. They are not able to give voluntarily informed consent because of the inherent inequity of their position" (Kaimowitz v. Michigan Department of Mental Health, 1973).

Knowledgeable consent implies that the professional worker proposing the intervention has been responsible in presenting alternatives and disclosing risks in a manner that will be understood by the person, whereas competent consent relates to the person's evidenced understanding of the information. The test for competence in informed consent varies with the risk involved, (i e, the test for competence to consent to experimental procedures must be more stringent than that for routine intervention).

3. Socialization

Socialization is a broad category that includes choosing social activities, room-mates, friends, etc. Assistance may be indicated when the dependent adult is unable to recognize potential dangers in social situations, or is himself in danger of being exploited by 'friends' or room-mates. Support may also be useful for increasing the availability of social activities when the dependent adult lives in a situation where social activities are limited.

Although it is generally recognized that some elderly, or mentally retarded persons may be subject to victimization because of their tendency to be overcompliant and non-assertive; care must be taken not to restrict the person's rights and thus denying as much personal choice and lifestyle freedom as possible. It is also doubtful whether a legally appointed decision-maker could enforce his or her personal choices in the area of socialization, if his or her ward refused to be persuaded.

Factors which would appear to be important in assessing competence in this area are the ability to identify one's friends or social activities, behaviour consistent with personal standards, and assertion, (Marlett, 1972; Rosen & Kivitz, 1973). Adherence to a specific set of values that agrees with those of the assessor should not be used as a determinant of competence to make choices related to friendships.

4. Personal routines

Assistance may be indicated when the dependent adult is unaware of his or her surroundings or routine health care needs and appears unable to assert himself or herself in diet, dress, etc. Protective service may also be needed when basic personal routines are not being maintained, or where the client is either

completely dependent on established routines or unable to use day-to-day services.

How can basic rights be protected?

The fight for recognition of basic legal and human rights for persons with disabilities has been mounted on two fronts: the Civil Rights/Disabled Consumer movement and the professional thrust to enhance the status and dignity of disabled persons, as an offshoot of the normalization ideology.

In Canada and Britain we do not have a history of legal confrontation, as has been the case in the United States. Nevertheless, persons who are disabled are forming coalitions to increase public awareness and legislative support for their rights to have a meaningful place in society. Cooperative planning by government, service providers and persons with disabilities is well underway in Canada, aimed at removing barriers to full participation. In Britain also, coalitions of disabled people are forming to effect existing policy guidelines aimed at providing quality services.

The first major step to the recognition of basic rights by professionals occurred in 1969 at the San Sebastien Symposium on Guardianship. This was followed by the U.N. Declaration of the Rights for Mentally Handicapped Persons in 1971. These documents affirm basic rights to medical care, education, training, rehabilitation, economic security, and community residential options. The charters clearly support the right of mentally handicapped persons to a qualified guardian to protect his personal well-being and interests when he is unable to do so. While such statements are laudable, Mittler (1984) points out that these and other statements of principle are sometimes "qualified almost out of recognition by phrases such as 'wherever possible', 'to the maximum extent possible' and, in recent U.K. legislation by 'subject to the availability of resources'".

If we are truly to entrench the rights of persons with a disability in the fabric of our systems, there must be mechanisms for disabled persons or those acting on their behalf to challenge the policies and practices which deprive them of their basic rights.

Mechanisms to protect basic rights

Advocacy is becoming a household word within the helping services. Roher (1984) suggests that there are a number of levels of advocacy starting with the natural advocates/parents or close relatives who adopt the posture of advocacy as a outgrowth of their relationship to the disabled person. Advocacy, which simply means that there is an active involvement in assuring the rights of the disabled person, has taken on a number of forms.

1. Self advocacy

Self advocacy is becoming a growing movement within the consumer sectors of society. Within Britain, self advocacy has been promoted by movements such as those represented in Williams and Shoultz's (1982) book, We Can Speak for Ourselves and Crawley's (1983) work on the development of self advocacy in adult training centres in England and Wales.

2. Advocacy by professionals

Professional advocates, lawyers and social workers, have a long history of speaking on behalf of their clients. In the British tradition, the social worker/advocate position is a very powerful one compared to North American standards. One of the most effective means of change is the coalition of professionals (teachers, work activity staff, parents and disabled persons). MacKinnon and Marlett (1981) present a strong case for professional/consumer social action in overcoming societal barriers as an integral part of family therapy.

An important outgrowth of social work advocacy is the movement toward ensuring rights and quality of service through policy. The recent developments toward raising standards in community care facilities is an excellent example of this. Through this process professional advocates have authority vested in policy and can intervene on behalf of the person in care.

3. Volunteer advocacy

Volunteer advocacy has become a powerful movement in many countries. Based on Wolfensberger's principles, citizen advocates accept the responsibility of speaking on behalf of their proteges. Advocates have been a meaningful safeguard of the human rights of mentally retarded persons, both children and adults. However, they lack the legal capacity to speak on behalf of their proteges and do not have legal authority to request documents or challenge services. Many within citizen advocacy are now questioning whether a legal backup system might be needed.

4. Public advocates

Public advocates are established in many countries through the ombudsman position wherein individuals have the means to challenge bureaucratic systems which at times override personal rights.

5. Guardianship

Guardianship in North America refers to the legal process whereby a person is granted substitute decision-making authority and is charged with making decisions in the best interests of a person who is considered, after due process, to be incapable of making decisions and acting on his own behalf. Given this

definition, perhaps a more appropriate British term would be tutorship, as guardianship has come to mean detention. The functions of the guardian are:

1. Monitoring direct services provided.

2. Deciding or consenting for the individual.

3. Advocating for services required to meet the individual's potential.

A recent publication (Apolloni & Cooke, 1984) presents a wide array of guardianship procedures presently in place within North America. The text is unique in that it provides the first compilation of both legislated and voluntary systems to promote normalized living for persons who cannot speak on their own behalf.

Issues in addressing the need for protective services

This last section represents some of the major debates which have emerged from the 10 - 12 year experience with modern guardianship legislation in Canada and the United States.

Who is in need of a substitute decision maker?

'In need of' combines two distinct issues - competence and availability of other sources of support. The issues of competence to make decisions are complex both ethically and technically. It is not difficult to decide that an aging confused patient or a profoundly retarded person needs support in making decisions. But how does one decide who, in the large grey area of moderate retardation or sporadic confusion, needs support. Marlett (in Apolloni & Cooke, 1984) has identified temporal anchoring, working memory and knowledge of alternatives as key factors in measuring competence.

Availability of alterative supports is a separate issue. If a person, considered unable to make decisions, has a family, a secure service placement (e g, nursing home) or an informal advocate, are they in need of a legally sanctioned advocate/substitute decision-maker? On the one hand, it can be a burden for families to obtain a legal sanction to do what they already do informally. On the other hand, families are often left out of decisions and may feel powerless to affect change if their family member is already in a facility and there are no alternative placements.

It is difficult to meet the needs of only those who require it. To cast the net too wide, to include more persons than are necessary, just to be safe, will cause serious problems:

- Persons labelled incompetent are likely to suffer loss of esteem and self control.
- Staff/parents tend to treat persons labelled in this way

as children, incapable of meaningful self determination.
- Society's beliefs about mental handicap and senility are likely to be reinforced.

2. What form should substitute decision-making/formal advocacy take?

McLaughlin (1979) discusses a social work model in which protective procedures are entrenched in policy. This avenue has many appealing features in that, in Britain, it is compatible with social work tradition. Some of the dangers inherent in this model relate to the ability to suppress advocacy when the advocate is paid by the same department that finances the service being monitored. The conflict of interest issue has been a major drawback in those jurisdictions which have not separated the responsibility of service from that of advocacy.

Another danger is even more serious, that of co-option. A worker assigned to speak on behalf of persons in an institution soon becomes seen as another staff person and because of close professional ties may listen too well to the staff and not well enough to the views of the person and his family. This is particularly important when the person has had institutional training but not experience with the clientele he is assigned to work with.

Legal advocacy/substitute decision-making requires due process, through public debate at the granting and at the review of the order. Legal processes affirm the seriousness of denying a person the ability to make his own decisions. The review process is the key to legal accountability, for it reviews not only the continued need for guardianship but also whether decisions made on behalf of the person have indeed been in his best interest. Both aspects are crucial to a just system. Young adults leaving structured school programmes and protective families may require an alternate support until adult skills and competencies develop. Without stringent safeguards young persons can become permanently labelled and treated as incapable.

The review process, in challenging decisions made, puts teeth into human rights but it is seen as a major threat for parents who must justify their actions to a court. The major problems with this approach lie in the cost and in the judiciary system itself. It can be cumbersome and time-consuming to follow due legal process. Legal costs make this impossible without a subsidy and the number of orders can overwhelm the court system in the initial stages as large backlogs of people are being processed. The judiciary needs to be well informed of the issues related to guardianship lest they 'rubber stamp' orders or treat the process in a perfunctory manner.

The United States in many areas has opted for a private, non profit alternative in which an association takes on the responsibility of personal advocacy, estate planning, and

substitute decision-making. Such an arrangement tends to lead to a more natural sharing of responsibility with parents as they prepare to hand over responsibility to a third party. These agencies have been recognized, financially and officially, by some states as an important link in the service chain. Other states consider such agencies as unnecessary encumbrances.

3. Who should be a guardian?

This poses a particularly difficult dilemma. Society views the mentally retarded adult or the confused elderly person as family property because both retain the characteristics of childhood. Any attempt to challenge a family right to be a guardian is met with fierce historical resistance. On the other hand, many parents argue that they are perhaps not the best people to encourage adult actions because of their comfort with/and expectations of a continuation of family routines in which the person is seen as a compliant child.

If there is no family, who should be appointed? Individual staff may have a close relationship with a person in need of a guardian but place themselves in the crossfire of conflict of interest when they take on legal decision-making responsibilities. As head of an agency, many administrators feel it is their responsibility to speak for all those in their care. Where it is true that they must be responsible to client needs and aware of individual differences, they are placed in a difficult situation of agreeing to treatment that staff has recommended and will carry out. Such a system, even with external review of decisions, removes the basic right to consent from clients.

Citizen advocates have successfully taken on the responsibility of legal substitute decision-maker as a way of formalizing their position. This relationship, established initially to help the protege (disabled person) realize his own unique lifestyle within a context of normalization, sets a positive tone for the protection of human rights through legal substitute decision-making and advocacy.

If all else fails and it is necessary for someone to assume the commitment of making decisions and acting as an advocate, a public alternative must be sought. There has been some debate about entrepreneurs who would be contracted to speak on behalf of individuals. While this may be feasible, it smacks of exploitation and, to this author's knowledge, such a model has not been realized to date. This leaves the professional guardian who assumes a caseload of persons requiring protective services.

As society addresses the fundamental issues of human and legal rights of its less capable citizens it learns a great deal about itself. The direction that Britain takes in seeking to meet the needs of adults who require protective services will provide a major challenge over the next few years and have an impact on all for years to come.

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SEXUALITY AND THE PERSON WITH A MENTAL HANDICAP

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Until about 1975, sex education for handicapped people usually meant the provision of information, often with the fervent hope that it would not be used, (AAPHER,1971; Fischer, Krajicek & Brothick, 1973). During the next few years, attempts were made to put sex education in a social behaviour framework, sometimes with little commitment to students becoming sexually active,(Kempton, 1978; Johnson, 1981). However, experience seems to indicate that these approaches are somewhat superficial, and that they are more meaningful to the person who has already experienced close relationships. Consequently, it seems that learning to be a friend may enhance the ability to become a lover.

Intimacy needs and self esteem in the rehabilitation process.

In the second edition of his book, Motivation and Personality, Maslow (1970) postulates that the basic needs of humans can be arranged in a hierarchy which commences with the physiological and culminates in the aesthetic. Generally speaking, needs which are lower in the hierarchy must be fulfilled before those at a higher level. Thus a steady supply of food must be accessible before people can focus upon their need for safe and secure dwelling places, and this desire must, in turn, be satisfied before those concerning love and self-esteem.

However, in Western countries, the basic needs for food and sleep and for safety protection have largely been met. Most handicapped people have a secure place in which to live and few are literally starving. Consequently, it is the higher needs of love and belonging and self-esteem which are our current concern.

Perhaps of all people in our societies, those who live with handicaps are particularly vulnerable to deficits of this kind. In adults, trauma or the onset of illness may precipitate both the overt and covert withdrawal of intimacy by friends or lovers, and rejection by formerly-accepting groups. For example, the young children of a father disfigured by burns may now be afraid of him, while the woman whose hands are deformed by arthritis may feel her lover's subtle withdrawal from her touch.

People with developmental disabilities often have somewhat different experiences. In many cases, as they will have lived at home with a loving, caring family, their needs for love and belonging may have been fully met during childhood. However, some may not have had the opportunity to experience and develop peer friendships, a lack which may produce difficulties in adulthood when love needs cannot be met by the family.

Unfortunately, many people have been denied a loving family home. They may have spent their early lives in impersonal institutions, or a succession of rapidly-changing foster homes in which there was little chance to develop loving relationships or a sense of belonging. When one considers Bowlby's (1969) work on attachment, or studies of the 'attic children' (Davis, 1940,

1947), it is surprising that more developmentally disabled people have not been permanently damaged by the lack of loving relationships in their early years. Perhaps for many, these needs were met at a minimal level by a particularly affectionate ward orderly or foster parent, but, nevertheless, it appears that some people have become seriously maladjusted due to these deficits.

In summary, there seem to be two main issues concerning the love needs of handicapped people. For those who have become handicapped as adults, the task is likely to be the restoration of intimate relationships, while people with developmental disabilities may need to learn how to develop loving friendships. However, as many non-handicapped people have difficulties with close relationships, many of the former group may also require education for intimacy.

Maslow (1970) proposes that when the need for love and belonging has been met, humans will focus on the need for self-esteem. He believes that all people have the need for a stable, firmly-based and high evaluation of themselves, and that this need has two components. The first is a desire for achievement, adequacy, mastery and competence, while the second relates to the need for recognition, status, and appreciation. Satisfaction of the self-esteem need leads to feelings of self-confidence, but the thwarting of these desires produces feelings of worthlessness, helplessness, and a resulting lack of motivation.

Research in the field of rehabilitation indicates a recognition of the value of self-esteem, particularly as it relates to effective behavioural performance, (Fitts, 1972). For example, Wolf and Wenzl (1982) have shown a positive relationship between self-esteem and academic performance in mildly mentally handicapped-emotionally disturbed children, and McGarry (1979) has related improved behavioural competence to higher self-esteem and internal locus of control in 42 mildly mentally handicapped adults. In addition, Morgan and Leung (1980) demonstrated that an assertiveness training programme increased the self-esteem of fourteen physically handicapped college students, while Simpson and Meaney (1979) reported a similar effect when a group of trainable mentally handicapped children learned to ski.

In the area of developmental handicap, much of the recognition of the importance of self-esteem is probably derived from the principle of normalization where the concept of the 'least restrictive environment' allows for the optimization of behavioural competence, (Wolfensberger, 1972). Consequently, much careful and painstaking work has been done to facilitate the acquisition of new skills, (Brown ,1975; Brown & Hughson, 1980). Working within a framework of research, demonstration, and practice, initial interest focussed on employment and home-living skills, but more recent programmes have considered the learning of leisure-time and social skills, (Beck-Ford & Smith, 1979; Ryba, 1979; Johnson, 1981).

Body image or schema is another important aspect of self-esteem. This refers to the mental idea and/or basic attitudes people have toward their own bodies and reflects the physical, aesthetic, and even social self-perceptions, (Singh & Magner, 1975). In reference to paraplegic patients, Berger (1952) has pointed out the importance of the integration of the physical disability into the body image, and this point is emphasized in self-help books such as Toward Intimacy (Shaul, Bogle, Harbaugh & Norman, 1978).

While behavioural competence and body image have been explored, there appears to be little research concerning the effect of intimate relationships upon the self-esteem of handicapped people. However, there is some indirect evidence from studies of mentally handicapped married couples, (Mattinson, 1970; Craft & Craft, 1979). These books mention the stability of the relationships, the partners' expressed wishes to stay together, and the focus marriage has given to their lives. The companionship between partners, and their social isolation from others are mentioned on several occasions. Consequently, one is led to speculate on a comparison between the self-esteem of the minority of handicapped people who have just one intimate friend and the majority who have none.

In presenting his concept of a needs hierarchy, Maslow(1970) comments on the interdependence of the components. While it is necessary that the lower needs should be largely satisfied before the individual's attention turns to a higher level, complete gratification is not required. He further comments that this phenomenon is most often seen in the interdependence between the needs of love and belonging and self-esteem! Evidently, he is referring to the cycle in which love provides the self-esteem necessary for performance which, if successful, increases self-esteem and love.

Nevertheless, in spite of some interdependence between needs, many rehabilitation practitioners may well have the wrong priorities. In the present state of the discipline, it is easier to concentrate upon the relationship between concrete performance and self-esteem than it is to struggle with the traditionally esoteric concepts of love and belonging. And yet this may be a grave error. How many people are currently learning vocational skills when they live in a desert of impersonality with its mirages of love and intimacy? It is suggested that we become more sensitive to the need for love and belonging, to the role of interpersonal relationships in the development of self-esteem, and to innovative methods of teaching handicapped people to meet their needs for intimacy.

Developmental aspects of intimacy

Morris (1971) speaks of a strong desire for intimacy among humans. He believes this has a biological basis as illustrated by the similarities between the stages of courtship in both humans and animals. Furthermore, he cites evidence from

prisoners in solitary confinement and young people alone in a strange city, that death by suicide might be preferable to a prolonged lack of close human contact. A statement which is quite devastating in terms of the unmet needs of many handicapped people.

Successful intimacy appears to develop along two parallel axes. One axis relates to intimacy within the family unit, while the other focusses on relationships with peers. The former begins with the intense intimacy between the parents and the infant child, before gradually diminishing through the rest of the life span. The latter begins with the shallow, temporary friendships of the two-year old, develops into the reciprocal companionship of adolescence, and culminates in the intense bonding of the mature adult, (Rubin, 1980). Of course, the two axes are interdependent, especially in terms of the child's ability to transfer family- learned intimacy skills to peer relationships. Infants who have experienced strong, intimate bonding with their parents will be better equipped to make strong peer attachments as young adults, (Morris, 1971).

For people with developmental handicaps, the relationship between sexuality and intimacy can produce difficulties. For many, it appears that the concept of gender identity emerges slowly, especially in the absence of appropriate male role models, and subtle cues to social behaviour may be unheeded without sensitive instruction, (Johnson, 1981). The result could be a mentally handicapped teenager who becomes involved in the exploratory sexual behaviour of young children. Discovery frequently results in accusations of child molesting, and the removal of the handicapped person from an environment where so much can be learned about relationships.

Aberrant behaviour may also occur if developmentally handicapped adults cannot meet their sexual and intimacy needs by culturally normative means. However, there are now many examples of adults who have met these needs with peers in appropriate ways, and enough studies of marriages, to demonstrate that this is a viable lifestyle for many handicapped people, (eg, Mattinson, 1970: Craft & Craft, 1979). This alternative must now be considered as a right, and not a privilege.

Myths and facts concerning the sexuality of people with a mental handicap

In presenting workshops to local associations for mentally handicapped people, three concerns appear to predominate:

(1) community standards;
(2) inheritance of mental handicap; and
(3) inability to cope with the responsibilities of marriage and parenting.

Let us now consider each of these concerns in more detail.

(1) Community standards

One of the concerns frequently expressed by people who favour sheltered, protected settings is that the inappropriate socio-sexual behaviour of mentally handicapped people will threaten the existing standards and well-being of the community. This is an interesting phenomenon in a society where:

(a) skin magazines are displayed in local grocery stores and subscribed to by a substantial percentage of the non-handicapped population;

(b) a movie such as Caligula can run for two years in Vancouver, playing to packed audiences;

(c) pornography is piped into private homes by pay TV;

(d) in many homes, Saturday night entertainment comprises renting 'blue' movies for family viewing;and

(e) many cases of sexual abuse involve mentally handicapped people as victims, due to their vulnerability, lack of knowledge and inability to express themselves.

If one were to include community standards as part of an education today, one would have to teach 'down', rather than up to such standards. The argument for protection from such hazards may have some justification. However, it might be questioned why one group of people should be afforded special protection when the rest of us have to do the best we can.

A second point is that institutionalized protection is itself a myth, for many people in institutions are sexually abused by staff. Reported incidents of sexually aggressive mentally handicapped males are often misrepresented. Typically the kind of thing that happens is along the lines of an institutionalized male being released on a day-pass to go downtown. At some point in the day, he feels the need to urinate but does not have the skills to find the washroom in a department store or shopping mall. Eventually the need is so urgent that he urinates in a street drain and is promptly arrested for indecent exposure.

Institutionalization, as Sigelman and Switsky (1978) found, is not conducive to intellectual or social development and can actually be destructive to any potential that might have existed in an individual, by rendering them dependent, malleable and childlike. However, most governments still allocate the larger proportion of funding for programmes for mentally handicapped people in institutions, with little considered reflection on the well-being of the clientele, (Flynn and Nitsch, 1980).

The need for facilities and programmes for mentally handicapped people is documented by O'Connor (1976), who conducted a survey on the availability of community services for

this group and found only the areas of health care and religion to be worthy of being rated as adequate.

On the more positive side, given proper training in integrated settings, there is evidence that mentally handicapped people can adjust to community living successfully. Unfortunately, most community environments provide ambivalent and contradictory messages about ways of developing intimate relationships. However, as relationship skills can be learned, competent, creative and sensitive teaching can help handicapped people to develop mutually-supportive intimate partnerships.

In the past relationship education has either been ignored or taught in a piecemeal fashion. Typically, it is only after the occurrence of a crisis that an individualized programme is implemented or a person gains access to an existing course. While these programmes may prove successful in the short-term, they fall far short of helping people to recognize their needs for intimacy and to understand how these can be met in an interpersonal relationship.

Therefore, relationship education should be comprehensive, systematic, and based upon developmental principles. It must recognize that handicapped people are qualitatively similar to others, and will pass through the same developmental stages. However, this may be at a slower rate or in a more fragmented form.In this educational process, chronological age will mean little, while the concept of developmental delay is of prime importance.

(2) The inheritance of mental handicap

Fears about the inheritance of mental handicap stem from the early 20th century writings of the eugenics movement and those concerned with a general decline in levels of intelligence, should mentally handicapped people be allowed to copulate freely. In actual fact, there is little support for the idea of mentally handicapped people producing large families of handicapped children. Mattinson (1973) reported only 7.5% of handicapped children from couples who were themselves handicapped. Reed and Anderson (1973) report the following data:

(a) Where both parents have an IQ less than 70, 40% of children have a similar level. However, 20% of children from such unions showed IQ's of more than 90.

(b) When one parent was mentally handicapped, so were 15% of the children, but 54% had IQ's in the average range.

(c) When neither parent was retarded, only 1% of children were.

(d) 83% of mentally handicapped children have non-handicapped parents.

(e) There appears to be more risk of inherited mental handicap with a handicapped mother than with a handicapped father.

(f) In relation to family size, there appears to be no correlation between measured intelligence and number of children.

Thus, the concept of mentally handicapped people running sexually amok and threatening the intellectual capacity of the human race is hardly borne out by the evidence. One further factor should be mentioned here however, and that is that traditionally, institutionalized mentally handicapped people have not had the opportunity to marry, and little evidence is therefore available on inheritance factors of offspring. There also appears to be correlation in some studies which indicates that infertility might be a natural control of inherited mental handicap.

(3) Marriage and parenting

As was mentioned in the previous section, data on the marriages of mentally handicapped people is only recently beginning to emerge. Of the research available, Anne and Michael Craft, who live and work in Wales have produced some valuable, interesting and very human studies of a longitudinal nature. Their evidence shows some interesting trends. For example, a study conducted during the 1970s to examine the effects and results of marriage between mentally handicapped people demonstrated the mental health benefits of such people being permitted to live married lives both within and outside of institutions. Among other things, the study showed that divorce was significantly less (four times lower) than that in the normal population. Most marriages were found to show the same behavioural range as normal marriages, with similar problems and benefits. Some of the marriages have lasted fifteen years.

Craft and Craft found 76% of the couples living independent lives in the community with only minimal supervision. In general, it seemed that such marriages were more beneficial to the partners when there were no children. There did appear to be valid concern for the intellectual and emotional deprivation of normal offspring born to parents who have a mental handicap. However, the marriages seemed supportive for the adults, and Craft and Craft, reporting on twenty-five couples, found only one person who wished to return to an institution. Thus, marriages between, or involving, people with a mental handicap would seem to reflect the same trends as observed in the non-handicapped population.

Unfortunately, society does not allow mentally handicapped people the same freedoms as the rest of the population. While those of us supposedly free of handicap may lose jobs, and wreck both cars and marriages, a mentally handicapped person

demonstrating similar behaviours would be labelled inept and then reinstitutionalized.

In regard to intimacy and sexuality therefore, the myths surrounding people who are mentally handicapped are mostly unfounded. Where apparently deviant socio-sexual behaviour does occur, it is often more a result of restricted and constrained environments which have provided little or nothing in the way of teaching appropriate social skills. Thus, the philosophy of institutionalization has tended to be a self-fulfilling one. Untrained inmates, released on day or weekend passes, commit socially unacceptable errors which are then interpreted as justification for reinstitutionalization.

In the area of marriage and parenting, the evidence would seem to demonstrate the same range of failures and successes as exists within the so-called normal population, with additional stresses being evident when children are born. The key point however, is that many aspects of the criteria required by controlling groups to justify marriage and parenthood, might equally well be applied to everyone, not just people with a mental handicap.

Teaching strategies and resources

In many human service agencies and community colleges, the sporadic attempts at teaching interpersonal skills have illustrated an additional perplexing fact. General learning principles are often not applied in this area. For example, while vocational skill training has incorporated features such as task analysis, jig construction and schedules of reinforcement, sex education may still use only verbal instruction, perhaps aided by line drawings, (Johnson, 1979). Consequently, it appears necessary to point out some of the learning principles that are especially important in relationship education.

The planning process

For both ethical and motivational reasons, it is important that the handicapped person has an active role in the planning process. This includes the power of veto in situations where the consumer does not wish to participate. Responsibilty for identifying the needs of mentally handicapped learners should be delegated by a committee to a person or people well-known and trusted by the potential learners. It might take the form of one-on-one interviews, or group input. The target group should receive an explanation of a planned course on Human Sexuality, and their responses and reactions elicited and noted by careful observation, questioning and honest answers. It should be made clear from the start that participation is optional. There should be no coercion to attend whatsoever, and it is the responsibility of the adult educator-consultant to stress the constant application of adult learning principles throughout the whole process. The same respect between educator and participant must pertain as that in any other adult programme planning

situation.

The hierarchy of priorities will evolve from the expressed needs of the learners and the desired outcomes of the local association or agency for mentally handicapped people. The criteria for determining priorities will have to be compiled in consultation with the sub-groups which are most involved. These will most likely be the staff workers and the people with a mental handicap. Priorities might be based upon the need for critical intervention (such as masturbating in public) and the needs most often expressed by the learners (such as how babies are made).

Materials, teachers and aides

Careful selection of instructors and aides and the fact that there should be inclusion of both sexes, has already been mentioned. Again, it must be emphasized that these people should be non-judgmental, flexible, open-minded and able to deal comfortably with people who may not know or use the polite middle-class terminology for body-parts and acts of intimacy.

In order to achieve maximum effectiveness, care must be exercised in the selection of materials. Those materials which portray men and women in stereotypical roles or situations should be avoided. Also, use of sexist language should either be rejected or translated into terms which exclude neither gender. It must be remembered that people with a mental handicap are more prone to literal interpretations than most other people might be. Thus, terms like 'man' or 'mankind' arouse mental images of males, despite well-worn arguments about generic origins (which, in essence amount to nothing less than statements of a desire to resist change). Since large numbers of the so-called non-handicapped population have enough trouble including females in everyday language, it is doubly important that sexist language be omitted in teaching mentally handicapped people.

Instructional design

Training in how to apply the principles of developmental learning is essential to the effective teaching of this type of programme content. No matter how apparently homogeneous a group of learners may seem on the surface, individual differences will soon emerge. This is true in any learning situation for handicapped and non-handicapped people alike. It is therefore imperative that educators have the skills with which to recognize individual differences and to adapt their programmes accordingly. It is a sad phenomenon that most areas termed Special Education are taught in terms of antiquated drill-and-skill techniques which ignore developmental principles inherent in any learning situation. The search for modes and content relevant to a particular learner is generally abandoned in favour of pre-packaged programmes which supposedly need no skilled professional to administer. In addition, one often hears the resistant complaint that it is impossible to individualize with a class of

'n' students. The 'n' is not a constant, for one hears it applied to large classes of thirty and groups of twelve alike. People seem to have many misconceptions as to the nature of individualization, the essence of which lies in the ways and means of presenting tasks. The skill lies not so much in the preparation of specific materials for a specific learner (although there are appropriate times for this), but in the presentation of materials and content whch can be used in an open-ended, many-faceted way.

The principles of teaching and learning here advocated are those of the cognitivist-developmental school which relate to the philosophies and principles of Piaget and Bruner. This does not, however, preclude other models such as those of Gagne and Briggs (1974) which can be employed successfully when specific knowledge and tasks are required that lend themselves to a more structured form of presentation.

The ability levels of the learners are therefore not a critical factor in determining content. They are critical in determining strategies and procedures once the teaching/learning is under way. The important factor is the learner's desire to participate willingly in the group. Given this basis, it is then the task of the instructors to devise ways and means of utilizing the prior knowledge and expertise of the group members to add to that knowledge.

Sources for objectives.

The learners themselves will be the ultimate sources for the objectives, with additional input from the instructor or programmer to fill the gaps in knowledge and skills. The objectives will also, of necessity, have to relate to some extent to the desired outcomes of the local association or agency.

Learning processes.

The background experience of the learners in the group must be utilized, with tasks presented in an open-ended format that facilitates the development of trust and self-confidence. Problems or questions requiring a straight yes/no response can inhibit even the most confident learner. The more real the tasks can be made, the better the learning is likely to be. This is one reason why homework tasks requiring the application of some of the social skills, is an important aspect of teaching. It aids in generalisation from the instructional setting to the outside world. Role-play of social interactions is a good way of providing a script and practice for learners to try.

Hands-on experiences are very important in some parts of the programme. Showing the practical devices for achieving birth-control is much more meaningful than a two-dimensional illustration. When learners have been exposed to the real thing, learning appears to be better assimilated into the long-term memory due to more meaningful impact.

In summary, it must be stressed that learning is holistic and involves what Gagne refers to as 'multiple aims' for instruction that incorporates factors such as stimulus and response, the presentation of information in such a way that it becomes internalized.

Learning outcomes

The following is a list of the types of outcomes involved in learning tasks, with an example of their applicability to sexuality programmes for mentally handicapped people:

(a) Verbal information: Knowing names, facts etc.
Application: Knowing names of body-parts, birth-control devices and what they do.

(b) Intellectual skills: Knowing rules and understanding concepts.
Application: How to ask someone out on a date; appropriate places to kiss, etc.

(c) Cognitive strategies: Applying rules and concepts to new situations.
Application: How to deal with unsolicited approaches by people in the community setting, (eg, the 'drunk' at the bus stop).

(d) Attitudes: Developing attitudes towards self and subject matter.
Application: Awareness of adult status and the right to be a sexual being.

(e) Motor skills: Capability involving action and use of the body.
Application: Role-playing situations requiring judgement of personal distance, moving away from a potential aggressor, etc.

Instructional techniques and devices.

Boyle (1981) points out that the only person really equipped with the knowledge as to the most appropriate methods and devices is the instructor. While some pre-packaged programme material such as the Alternative Route is useful in suggesting materials and techniques, it must be adapted to the actual situation. In the sexuality programmes, there is usually a combination of materials brought from home by both the learners and the instructor, and some professionally developed ones, such as the Kempton slides. Those strategies should be employed which appear to produce the best results. For example, in the Kempton slides, diagrammatical pictures showing isolated parts of the body can cause a lot of confusion. The slides which show a real person, with a focus on one particular body-part, will be more effective in long-term retention. The use of three-dimensional models such

as mannikins will usually generate much interest, especially when a description of sexual intercourse is requested.

Base-line data.

Collection of information that indicates what is known by the learners prior to the course is very important for purposes of summative evaluation. Pre and post-testing enables the instructor to see what components of the programme have been effective and where improvements are needed. It also provides evidence for purposes of accountability and a measure of achievement of the stated goals and objectives. The sexuality programmes should not be implemented without this component, (see Appendix A, for sample pre and post test).

Pre-test and client contact.

Contact with participants prior to the first learning session is advisable. Meeting face-to-face with a stranger on the first night of class is a fearful prospect for many adult learners. The entry process can be made easier when a person who is already known to the students has been present at the pre-test and contact interview. A staff member or itinerant psychologist can sometimes provide this service. The actual pre-test can be quite brief and fairly simple, posing questions that relate to the proposed content of the forthcoming programme, (see Appendix A). In addition, the student can be told what the course will entail in terms of knowledge and participation, and she/he can be encouraged to make further suggestions or to ask questions. Data collected at this point should be retained for purposes of accountability and effectiveness.

Formative evaluation.

Ongoing, or formative evaluation and refinement of objectives should be a natural component of the programmes being taught. This strategy helps to keep things on target, to monitor progress and to make necessary adaptations. It can take the form of anecdotal notes subsequent to each session taught, or after a series of sessions. The evaluation described in Stage 5 is primarily formative since summative evaluation warrants attention of its own at the programme termination point.

The model.

The model, as shown in Figure 1 represents the major generic, conceptual components and their sequence in the planned delivery of sexuality programmes for adults with a mental handicap. This conceptual framework and sequence represent a format based upon the writers' own experience. The progressive stages are those which appear to have occurred repeatedly in the planning, from intervention point to implementation of programmes. By constructing such a model, it is therefore hoped that the process may be rendered more effective and less haphazard. Specific aspects, precautions and requirements can be

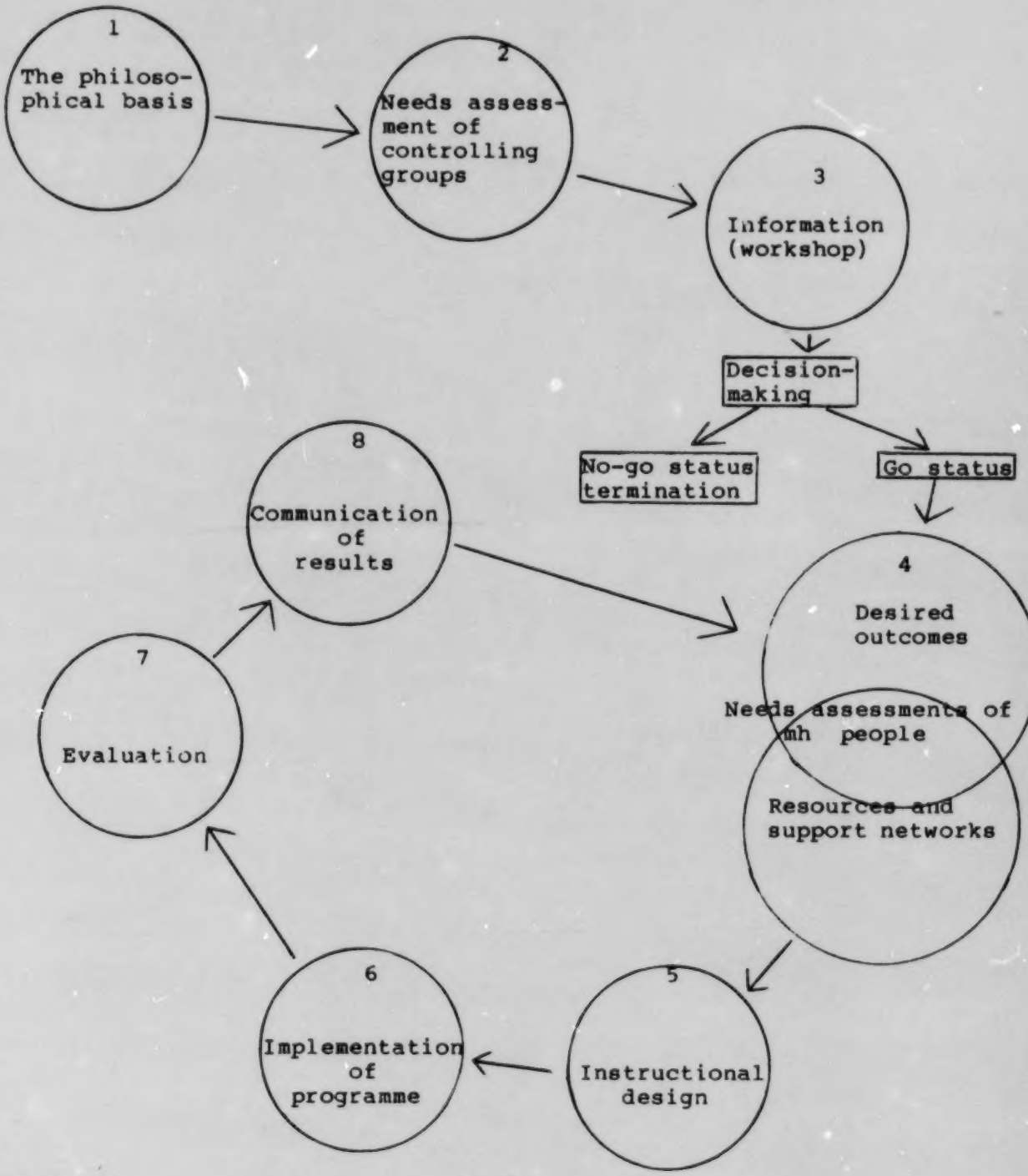

Figure 1

Model of the generic concepts in the planned delivery of human sexuality programmes for people with mental handicaps.

noted and checked in a clear format, and strengths and weaknesses identified as the planner proceeds. In further explanation it should be added here that the stages depicted in the model are those considered by the writers to be the major events.

In the model, the generic stages progress from numbers one to eight, at which point it has been found that a new sequence begins whereby Stage Four would be the second-time-around entry point with revised outcomes based upon what has occurred and what is needed subsequent to the completion of the initial programme. As has already been stated, the first three stages comprise an introductory, or critical intervention lead-in to the actual planned delivery of a sexuality programme. (For a checklist of this model, see Appendix B)

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APPENDIX A

SEXUALITY COUNSELLING COURSE FOR MENTALLY HANDICAPPED ADULTS. PRE AND POST-TEST DATA.

NAME:_____ AGE:_____ GENDER: Male Female

PRE-TEST DATE:_____ POST-TEST DATE:_____

STIMULUS	RESPONSE Pre	Post
1. Show the client picture no.1 and ask: Which person is most like you?		
2. Ask the client: Why?		
3. Show the client picture no.1 and ask: Is it o.k. for them to be doing that? (Yes)		
4. Show the client picture no.2 and ask: Is it o.k. for these people to be doing this? (Depends on situation)		
Note: At this point, warn the client that you are going to show them a picture of some nude people.		
5. Show the client picture no.3 and ask: Which person is most like you? (Either of the two centre figures)		
6. Show the client picture no.4 and ask: What is the name for this part? (Point to breast, vagina, penis, scrotum)		
7. Show the client the condom and ask: Do you know what this is called? (rubber, safe, condom, etc.)		
8. Ask: What is it used for? (Stop babies, etc.)		
9. Show the client the packet of birth-control pills and ask: Do you know what these are?		
10. Ask: What are they used for?		

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APPENDIX B

Checklist for the model's generic concepts.

1. The Philosophical Basis.

- What is the policy statement of the society or organization?
- Is it conducive to normalized living and intimacy needs?
- What are the attitudes of the community?
- Do the programmer's values clash with those of the society?

2. Needs Assessment.

- What do people say they want from sexuality programmes for mentally handicapped people?
- What information needs to be provided?
- How can the unexpressed needs of people be reached?
- What patterns and questions arise from response to a questionnaire?

3. Information (Workshop).

- Are people willing to participate?
- What institutional and individual constraints arise?
- Participants complete a sexuality attitudes self-assessment.
- Consciousness-raising about myths of sexuality of mentally handicapped people.
- Presentation of possible materials and resources.
- What local resources are there in terms of funding, accommodation, materials, instructors etc.?

4. Desired Outcome; Resources and Support Networks.

- What do the mentally handicapped learners say they need to know about?
- What are the gaps in their knowledge?
- What goals need to be attempted?
- Priorize the needs.
- Determine the programme content, using resource materials.
- Select teachers and aides of both sexes.
- Which community professionals can add to the programme?
- Where will the course be held?
- Is the programme feasible in terms of funding?

5. Instructional Design.

- Must be flexible.
- Use learners' own experiences.
- Base-line data: pre-test (preparation of).
- Use developmental principles: open-ended tasks and questions.
- Use formative (ongoing) evaluation to modify programme.

6. Programme Implementation.

- Comfortable setting, ideally homelike.
- Teacher prepares materials ahead of time.
- Administer pre-test to each person individually.
- Tell learners what to expect and ask what they want to know.

7. Evaluation.

- Post-test results.
- Were objectives achieved? Did the learners learn?
- What changes should be made next time?
- Was attendance consistent?

8. Communication.

- Report results of the programme in newsletter.
- Report to groups: staff, parents, community workers etc.
- Let other local associations know about your project.
- Let the mentally handicapped people give their own feedback and input.

RECREATION AND LEISURE SERVICES FOR HANDICAPPED PERSONS: CHANGING STAFF ROLES

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Introduction

With the growing appreciation of the physical, psychological, and educational benefits of leisure and recreational activities, there has been a dramatic increase in the participation of mentally handicapped persons. Often however, leisure and recreation have not been seen as a priority by funding agencies or by rehabilitation personnel. Also, present practices are frequently inconsistent with current philosophical approaches toward the provision of services for mentally handicapped persons.

Techniques and methods which promote the integration of mentally handicapped persons in normalized settings and activities have now been applied to recreative programmes designed for this population on a limited basis. As these practices are adopted more extensively, there will be significant changes in the roles and functions of personnel providing these services.

Benefits of leisure/recreation programmes

In a review of the literature describing fitness deficits experienced by mentally handicapped persons, Bunker (1978) found evidence of substantially subaverage strength, higher levels of fat, and lower levels of muscular endurance and power, with greater susceptibility to fatigue and less tolerance for endurance tasks. In addition, it appears that there is a decreasing ability to improve motor performance with age when compared to a non-handicapped population. These deficits can be alleviated by maintaining a reasonable level of fitness. For example, a jogging programme for mentally retarded adults produced a higher level of cardiovascular fitness and work performance than was measured in a control group, (Beasley, 1982). Benefits of physical fitness for mentally handicapped persons in I.Q., academic performance, self concept, and social interaction with peers are described in a review of the literature provided by Moon and Renzaglia, (1982).

Beck-Ford and Brown (1984) identify a number of valuable by-products provided by leisure involvements. These include the opportunity to develop and practise skills in the areas of time management, money handling and budgeting, transportation, and information seeking. Wehman and Schleien (1981) suggest that recreational activities will also provide relief for families and act as competing behaviours to self stimulation and stereotypic responses. There are then, several secondary benefits as well as those directly available to the mentally handicapped participant.

Present practices and problems

In recognition of these benefits and in an effort to provide handicapped persons with a more fulfilling life, organized sports programmes such as floor hockey leagues have been established, (Nychuk, 1979). Special camps and reserved times at bowling

alleys and swimming pools are made available for groups of handicapped people, (Wolfensberger, 1972).

The most highly visible and extensive programme is the Special Olympics. It was established in 1968 to improve public awareness of the need for sports programmes for mentally handicapped individuals, and to create such programmes. These objectives appear to have been met with participation increasing from 1000 persons in 1968 to 700,000 persons competing in 16 different sports in 1977, (Orelove, Wehman, & Wood, 1982). The rapid expansion in services such as the Special Olympics and floor hockey leagues has provided opportunities for individuals to compete against those of similar abilities in situations where the focus is on participation, rather than competition, in a reinforcing, non-threatening atmosphere, (Orelove et al., 1982).

In spite of the expanding interest and involvement in these activities, a number of authors, particularly those discussing services in Canada, suggest leisure/recreation programmes are seen as a low priority or a frill by funding agencies and government, (Hutchison and Lord,1979; Lord, 1981; Beck-Ford and Brown, 1984). Even within the field of rehabilitation the attitude that leisure pursuits are nothing more than diversionary activities seems to be prevalent. Beck-Ford and Brown (1984) found only one article relating to leisure in the 1979 proceedings of the Fifth Congress of the International Association for the Scientific Study of Mental Deficiency, (Mittler, 1981). An examination of the proceedings of the Sixth Congress (Berg, 1984) reveals no articles on leisure or recreation. This may suggest that the area is not seen as a high priority anywhere in the world.

These attitudes and the group activity structure of many of the present leisure services for handicapped persons have produced staff roles which centre around arranging or providing recreational events and encouraging handicapped people to participate, (Wolfensberger, 1972; Reynolds, 1981). The approach has been one of ensuring individuals are 'exposed' to various recreational activities rather than providing systematic training of important and necessary skills.

Specific staff functions have included securing facilities, such as bowling alleys or stadia for track and field events and recruiting volunteers to assist in timekeeping, scoring and other organizational aspects of operating leisure/recreational events, (Orelove et al., 1982). Volunteers are often used to provide instruction in activities such as camping, cooking or arts and crafts.

Staff responsible for recreational programming may advertise activities and encourage individuals to sign up, or in some situations may simply schedule them into a leisure programme without consultation. Interactions between staff and participants are frequently aimed at generating enthusiasm. There may be some demonstrations and suggestions to assist them

in completing the activity. The primary focus, however, is on administrative and organizational functions and those handicapped individuals not seen as capable of participating fully in the activity are often excluded.

Changing Directions

The normalization ideology has had a dramatic impact on our views of what constitutes appropriate services for handicapped persons. Wehman and Schleien (1981) indicate that this philosophy will continue to affect staff roles and determine the techniques and approaches we adopt in supporting the individual's development of recreative interests and skills. The new direction these services should take is suggested by recommendations developed at the 1970 National Conference of Retarded Young Adults in Malmo, Sweden (Nirje, 1972). In regard to their leisure time, the conference participants stated that they wanted to:

(a) be together in small groups;
(b) be with same age non-handicapped peers;
(c) have leaders of their own age;
(d) have access to better leisure resources; and
(e) participate in planning and carrying out the activities.

They also wanted their vacations to:

(a) be with non-handicapped peers;
(b) include preparation courses in areas such as language and manners; and
(c) be spent according to their decisions and wishes.

Finally, they called for the abolition of segregated summer camps for the 'Retarded'.

Many of the leisure/recreation programmes presently in operation pay little or no attention to the wishes expressed above. The Special Olympics, the most extensive recreation programme for handicapped persons, is seen as inconsistent with the normalization principle, (Orelove et al., 1982). There are no skill development oportunities for relating to and interacting with non-handicapped peers. Also, there is a large group of handicapped observers, a division between the two groups which may contribute to stigma with sympathy, pity responses, and self fulfilling prophecies about negative characteristics. Orelove et al.(1982) suggest several changes to programmes such as the Special Olympics that would ensure increased opportunities for integration.

In a review of existing leisure time programmes, Wuerch and Voeltz (1982) outline a number of inconsistencies with the normalization ideology. They indicate that these programmes are generally conducted in specialized environments, require entry level behaviours more severely mentally handicapped persons do not have, and are not chronologically age appropriate. They

further suggest that existing age appropriate programmes are frequently passive in nature.

Unsuccessful efforts to promote integration or mainstreaming, particularly of more severely handicapped persons, may be due largely to inappropriate theoretical approaches, (Baumgart, Brown, Pumpian, Nisbet, Ford, Sweet, Messina, & Schroeder, 1982). The notion that severely handicapped individuals must pass through the same developmental sequences as non-handicapped persons or that there must be a reasonable expectation that they will be able to perform all the skills in an activity before instruction is provided, restrict rather than foster integrative opportunities. Denying access to activities, because an individual does not have the prerequisite skills or, because he or she is not expected to perform independently, will often result in exclusion rather than training and participation.

To overcome this problem Baumgart et al. (1982) have proposed the 'principle of partial participation' which suggests that an altered form of involvement in a chronologically age appropriate activity or environment is more advantageous than exclusion as it promotes the image of the handicapped person as an involved, active and contributing member of thecommunity. This approach uses systematic training and selection from a variety of types of adaptations following a careful and extensive assessment of the relevant skills and the setting in which they are to be used.

In addition to the changing ideological basis for providing services to handicapped persons, the concept of leisure/recreation for this population has been greatly expanded. Traditionally, sports competitions and physical skills have been emphasized, but more people-oriented services that are responsive to community needs are required, (Hutchison and Lord, 1979). The beginnings of a wider range of alternatives is evidenced by recent articles on programmes for handicapped adults in photography, (Giandreco, 1983), playing video games, (Sedlak, Doyle, & Schloss, 1982), and social dance, (Crain, McLaughlin, & Eisenhart, 1983). In their recent book, Beck-Ford and Brown (1984) have dealt with the range of leisure activities as a four level continuum made up of spectator activities, social activities, physical activities, and creative, self-actualizing activities. Wehman and Schleien (1981) have broken down leisure alternatives for severely handicapped persons into the categories of hobbies, sports, games, and object manipulation activities, (eg, throwing a frisbee).

The concept of leisure and recreation has also expanded in regard to the objectives to be achieved by the handicapped participant. Activities are not undertaken solely for enjoyment or to occupy free time. There is now a concern with the development of related social skills in an age appropriate, integrated setting (Wehman and Schleien, 1981; Weurch and Voeltz, 1982; Brown, Ford, Nisbet, Sweet, Donnellan, & Gruenewald, 1983). In planning services the additional benefits of these programmes

should be maximized through the use of creative procedures and arrangements.

The principle of normalization has redefined what are regarded as appropriate services for mentally handicapped persons and has prompted a wider concept of leisure/recreation programming that includes the range of options available to the general population, and supports the individual's participation in non-segregated environments and activities. A number of techniques and methods necessary to the implementation of more normalized leisure services have been developed and demonstrated on a limited basis. As the application of these techniques becomes more generalised, there will be a dramatic change in staff roles and functions.

New Methods and Techniques

Providing leisure/recreation services for handicapped persons involves selecting the activities, deciding what skills and adaptations are necessary, implementing an adequate training procedure or adaptation, and ensuring that the handicapped person can generalize newly acquired skills and access community resources. An examination of the methods and techniques which are being applied at each of these steps will help to identify the competencies leisure/recreation staff will need in order to provide normalization based services.

Identifying Leisure Interests

A variety of approaches to selecting leisure/recreational activities have been suggested. The author's experience suggests that mentally handicapped persons are often not consulted about the leisure time pursuits in which they are involved. They may simply be scheduled into arts and crafts classes, or told where they will be spending their vacation. Lord (1981) suggests the interests of the handicapped person should be considered in the selection of activities but provides no suggestions as to how these might be assessed.

Wuerch and Voeltz (1982) developed a curriculum using parent input regarding their preferences and values, and materials they had in their home or would be willing to purchase if their handicapped teenager could use them. They also sought information from parents as to their son or daughter's present interests and activities. These were then judged by teachers on whether they facilitated normalized leisure behaviour, whether they met the needs of a wide variety of handicapped persons, and whether the logistical demands associated with these activities supported their inclusion in the curriculum. Finally, a five item checklist was completed by teachers to assess the level of interest displayed by the student in interacting with various leisure materials.

Unfortunately, this procedure led to the selection of activities such as using Lego blocks which Wuerch and Voeltz

(1982) describe as appropriate for adults. Other materials and activities considered acceptable throughout the life span of the handicapped participant include 'Lite Brite' and rolling marbles down little ramps. It is difficult to see these as age appropriate for a thirty year old man however, and these selections bring the validity of their procedure into question.

Wehman and Schleien (1981) provide a model for the selection of leisure skills which requires answering a sequence of questions related to:

1. preference - the present skills and interests of the individual
2. functioning - general capabilities and needs
3. physical characteristics that could interfere
4. age appropriateness
5. access to materials - equipment, financial resources, transportation
6. support of home environment

A leisure skills assessment is also presented which utilizes various behavioural assessment techniques to measure preference and the level and direction of related interaction. There is also an attempt to identify the quality of the leisure behaviour by considering whether the activity is goal directed, chronologically age appropriate, or too simple or too difficult. The level of inappropriate social behaviour displayed during the activity is also considered.

The approach to leisure pursuit selection described by Beck-Ford and Brown (1984) is very different from that above. The programme they describe involves the systematic development of decision making skills as the individual moves through a continuum of increasingly difficult awareness activities and practice in selecting from alternatives. For example, at level one of the programme the individual makes a guided two choice decision which has short term consequences, while at level four decisions are independently based on extensive investigation and result in a long term commitment.

An approach which introduces the individual to a wide range of possible choices and develops the necessary decision making skills to allow the exercise of one's personal freedom to select fulfilling leisure pursuits appears consistent with normalization ideology. Inferring preferences through techniques such as latency observations may be necessary with more severely and profoundly handicapped persons and may be a useful validation procedure for individual choices. This does not, however, support the individual's growth and development, or promote the least restrictive alternative for the handicapped person to the same extent as incorporating independent decision making training into a leisure skill programme.

The use of behavioural assessment methods to define the interaction patterns and intensity between participants and with

materials, could be useful in maximizing the benefits of the activity to the individual. For example, this data may suggest alternative environmental arrangements that offer expanded social contact with non-handicapped peers. A combination of these techniques together with a focus on the development of independent decision making may provide the most productive approach.

Skill Assessment

To identify the skills or adaptations needed by the mentally handicapped person preparing for participation in a leisure activity, a skill sequence is often generated through a task analysis of the activity,(Wehman and Schleien, 1981; Wuerch and Voeltz, 1982; Cuvo et al., 1983). The individual's performance on each step of the task analysis is then observed and evaluated.

While this approach is particularly useful for progressive leisure activities which can readily be presented in an easy to hard sequence, such as throwing a frisbee, a discrepancy analysis procedure will be more useful with chained leisure skills, (Wuerch and Voeltz, 1982). In these activities the skill sequence is quite rigid. The individual must perform the complete sequence in precisely the correct order before any result is obtained. For example, a specific set of procedures are necessary to initiate a video game and the appropriate cues must be recognised if the alien beings identified as evil are to be destroyed. The discrepancy analysis involves the specification of all the skills utilized by the non-handicapped individual in the leisure environment of interest and comparing this list to the skills demonstrated by thehandicapped participant. The discrepancies between these two lists describe the training and adaptations necessary to ensure the handicapped person's involvement in that environment.

While the above discussion was developed primarily from material describing approaches with the severely handicapped, Beck-Ford and Brown (1984) suggest these behavioural methods are applicable across the range of handicap. They also provide a checklist assessment form which highlights client needs in the areas of leisure awareness, self awareness, decision making, personal interaction, and leisure and allied skills. This assessment provides training objectives which promote the individual's development of independence in planning and participating in recreational pursuits rather than focussing exclusively on the skill sequences for specific activities.

In selecting an assessment approach it is necessary to keep in mind the goal of increasing the handicapped person's control over their leisure lifestyle as well as promoting their involvement in specific recreational activities. The assessment process will reveal the areas where training or adaptations are necessary to allow participation. The discrepancy analysis approach will also suggest related skills, such as money handling or social interaction, that must be considered if the individual

is to participate fully. An adapted form of the job inventory evaluation developed by Belmore and Brown (1978) would provide a comprehensive and systematic assessment of the skill and adaptation requirements in specific leisure environments and would be particularly useful when training a severely handicapped person.

Training procedures

Teaching the specific leisure skill frequently involves the use of an instructional cue hierarchy system to assist the participant in acquiring the individual steps of the task which are then chained together. Sedlak at al. (1982) used this approach following two demonstrations of a video game called Super Invaders. One to one training of three severely mentally handicapped adolescents was successful on a schedule of fifteen minutes, three times per week.

Cuvo et al. (1983) demonstrated acquisition of the standing long jump and the fifty yard dash using a similar method with four severely and moderately handicapped adolescents. Stainback, Stainback, Wehman, and Spangiers (1983) also used an instructional cue hierarchy system, which moved from waiting for an independent response to a verbal cue to a gesture or touch and, finally, to physical guidance if a correct response was not given to the previous prompts. They taught three physical fitness exercises to profoundly handicapped individuals each of whom was described as either violent or aggressive. The use of a primary reinforcer was also utilized in this situation.

Wehman and Schleien (1981) have used prompting, fading, and modeling procedures with an instructional cue hierarchy system in field testing 600 task analyses of specific leisure skills. They also recommend the use of reinforcers selected on an individual basis following a reinforcer sampling process. The ten activities Wuerch and Voeltz (1982) included in their curriculum are taught in a similar fashion, but they also utilized a total task approach as well as the chaining procedure.

Use of Adaptations

As indicated previously, the 'principle of partial participation' suggests the need to consider adaptations if handicapped individuals are not to be excluded from chronologically age appropriate activities. Wehman and Schleien (1981) have applied this principle to the leisure area and have described the various types of adaptations which might be considered on a individual basis. The categories they describe include:

(a) material adaptations - special equipment such as bowling ramps or beeping balls;
(b) procedural or rule adaptations - such as one dribble for several steps in basketball;
(c) skill sequence adaptations - rearranging sequence of

component steps;

(d) community based facility adaptations - such as basketball hoops dropped from ten to six feet; and
(e) lead-up activity adaptations - one or a series of alterations designed to lead to full participation.

The creative development of individual adaptations could greatly expand the leisure options of many handicapped individuals.

Generalization

Although it is necessary to ensure learners can make use of skills in new situations, generalization takes on even greater significance when skills are to be used across a range of integrated environments. A review of research on the generalization of positive social behaviours indicates that this process does not occur spontaneously with severely handicapped persons, (Stainback, Stainback, & Strathe, 1983). It was found that specific programming procedures must be incorporated to promote generalization across settings, individuals and responses.

In their review, Stainback, Stainback, & Strathe (1983) identify a number of procedures and situations which have assisted generalization. These include:

(a) selecting training objectives which have a high probability of reciprocal feedback from peers;
(b) moving from a high frequency or continuous reinforcement schedule to intermittent social reinforcement typical of the natural environment; and
(c) varying antecedent stimuli in the training situation to minimize differences with the natural environment.

To promote generalization across settings, they suggest training in a variety of settings and time slots, with various trainers and peers. Also, training positive social behaviours during different activities will assist transfer of these skills into new situations.

In a well designed study, Stainback, Stainback, Wehman, & Spangiers (1983) examined the ability of three profoundly retarded adults to generalize physical fitness exercises from an individual class to a group class. Even though antecedent and consequent events were analyzed in each of the settings and varied systematically to minimize differencesbetween the situations, there was a lag in the performance of the exercises after the transition was made. It was also found that generalization of exercises that were acquired through a structured training process was much faster than for untrained exercises.

Wehman and Schleien (1981) describe a series of procedures to promote the generalization of leisure skills including the use of naturally occurring reinforcers and altering reinforcement

variables by systematic fading, delaying delivery, use of an intermittent schedule, and reducing the strength of the extrinsic reinforcer. They also advocate varying the stimulus conditions by introducing irrelevant or distracting stimuli, utilizing a variety of trainers, and conducting the training in different settings.

It is clear that procedures for the generalization of leisure skills should be an integral part of the acquisition process if handicapped persons are to utilize the behaviours they develop during training. Staff must be aware of this need and skilled in the application of the necessary techniques.

Integration and mainstreaming

If we are to be successful in assisting disabled persons to move out of segregated leisure activities and environments, careful planning is necessary, (Taylor, 1982; Salend, 1984). Many of the procedures developed to facilitate integration and mainstreaming have focussed on moving handicapped students into normal school settings. Some of these practices are likely to open up normal leisure settings and programmes to disabled persons. Brown et al. (1983) describe a variety of benefits relevant to integrated leisure situations, (eg, logistical benefits related to accessibility and transportation, staff utilization). The non-handicapped participants will be provided with a more realistic perspective of handicap as well as a better personal perspective of their relative situation. The benefits to handicapped persons are also outlined in regard to proximal, helping, service and reciprocal interactions.

In order to access these benefits, a number of strategies and considerations have been identified. Taylor (1982) suggests that the ratio of handicapped persons in an integrated setting should be similar to the natural proportion in the population and congregating disabled individuals in isolated areas is to be avoided. Facilities should be used at times when non-handicapped persons are also there. Co-operative activities between handicapped and non-handicapped participants could be encouraged or a buddy system might be utilized. Lord(1981) presents a buddy system model and outlines a procedure for preparing support persons.

In order to ensure adequate planning for integration a task force approach has been suggested. In-service sessions for regular recreation personnel together with handbooks and visits to programmes for handicapped persons are also recommended, (Taylor, 1982; Salend, 1984). The inclusion of parents in planning and presentations will also enhance the possibilities of accomplishing a high level of integration, (Taylor, 1982).

An important consideration in promoting integration is attitude change. Stainback, Stainback, Strathe, and Dedrick (1983) have demonstrated a change in attitudes and stated behavioural intentions among regular school teachers through the

use of reading materials and small group discussion. Disability simulations, disabled speakers, and structured contact are additional procedures that have demonstrated value in altering peoples' perceptions, (Peck & Semmel, 1982; Taylor, 1982).

Lobbying for the inclusion of handicapped persons in generic recreation and leisure services with government may also produce desirable results, (Taylor, 1982). The adequate preparation of the handicapped person for involvement in these programmes is, however, a necessary precondition to all of these procedures.

Changing staff roles

Staff providing leisure services to handicapped persons will be faced with an expanding range of duties and functions. Planning and providing large scale segregated recreational events will become a decreasing job requirement, (Reynolds, 1981). This will be replaced by increased direct assessment and training interactions using behavioural techniques and approaches with individuals and small groups. Evaluating new leisure activities and environments to determine the training and adaptations each individual client requires is also necessary if they are to participate with non-handicapped peers in age appropriate activities. One of the major role changes however, will be the development of advocate and community liaison functions to promote the involvement of handicapped persons in generic leisure services, (Reynolds, 1981). The staff person will require skills in presenting information on disability, facilitating small group discussions, and the use of other attitude change strategies.

Planning should begin, both to promote the coming changes as well as to prepare for them. In-service training and continuing education courses need to be developed to support leisure and recreation personnel through the coming transition. Unless these changes are actively pursued the integration of handicapped persons will continue to be limited by the lack of appropriate attitudes and skills of the staff serving them.

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PROGRAMME AND MANAGEMENT ISSUES IN THE DEVELOPMENT OF HABILITATION PROGRAMMES

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Introduction

This paper is directed to some of the interface issues between management and programme development in the wide range of agencies which deliver services to the rehabilitation field. These may be boards of education, health services, private agencies, or research and demonstration centres.

Directors and managers of programmes do not often have formal training for these roles. Thus it would be helpful if people who manage and direct rehabilitation projects could have the benefit of experience that others have gained, sometimes quite unwillingly! There needs to be a wider range of formal preparation and internship for carrying out such roles. If I had received such an education I might have avoided a number of pitfalls and perhaps have facilitated the development of operations more effectively. Thus in putting forward my comments and recommendations I am relying, to some degree, on adverse experience. It is my hope, as within the field of mental retardation, that those deprived in the early stages show greater growth at a later point in time. It is with this analogy in mind that I have the presumption to make the following comments, for as you will see, I am indeed critical of some of the models that we have now built for administrators and managers. I offer my comments not as definitive recommendations, but as situations which need to be discussed and debated. For my own part, I have had the experience of being a frontline staff member, as well as a coordinator or head of a variety of units. I have sat on a range of boards and executives, both as a director and also as a chairman. Such experiences bring headaches, but they also bring considerable rewards. Among the latter is the fact one meets so many people who are willing to give advice and to back it up with hard work - which makes one's job easier. Sometimes one has the opportunity of helping to bring together disparate groups through a consortium, or in other cases, assisting a government department in bringing together two agencies which now must function as one. In an interesting way these experiences, and I comment on them because they are my data base, have led in a number of cases to remarkably similar conclusions. These I now wish to share with you.

Management issues in rehabilitation services

In discussing management issues I am referring to boards of management, advisory boards and consortia of staff which provide recommendations for the functioning of an agency. All adult training centres and their counterparts should be involved in such processes. The fact that many centres in the United Kingdom do not have advisory boards, seems to me to be a glaring omission. Within the Canadian scene many adult training centres are privately established agencies with boards, executive committees and advisory structures. Counterparts of these are necessary if agencies are to run effectively and not be lost in a wide bureaucracy which does not deal with individual client concerns.

We have entered a period of crisis in relation to the management of agencies working in the rehabilitation field. There is the basic issue of the role of boards of management, boards of health, and boards of education. There is a knowledge gap at two levels. First, board and advisory personnel lack a general understanding of the role of a committee and also board members lack knowledge of their general and specific aims and responsibilities as they relate to the rehabilitation field. Second, there is a crisis in respect of the knowledge of senior personnel who are directing agencies working for handicapped persons in terms of their general knowledge of agency functioning and direction, and their specific knowledge of rehabilitation activity, staff and client functions. The problem is that the very people who will deny this are often the ones where the comments are most apt. However, I would like to take away the personal issues, for there is little doubt that the majority of people contribute what they can and are dedicated to the agencies they serve, given the knowledge, time and expertise that they have. Likewise, managers and directors provide the leadership that they can. They are often dedicated persons who give their best, but who may not have been in a position to receive formal knowledge of their specific position nor had the opportunity to train under the direction of people who had gone before them. Without these attributes it is difficult to see how services can radically improve. We have not yet developed the mechanisms for incorporating successful change into the system on a general basis. The advances and changes in the field are so great that most agencies cannot, even if they are recognized as demonstration agencies or centres of excellence, keep up with the developments of research and practice, and continually be at the cutting edge of rehabilitation.

This all argues for a number of fundamental changes. Changes at government level, at local authority level and also amongst personnel within an agency. There must be a recognition of what is possible at a demonstration level within the rehabilitation field. The question must be asked 'Are we providing the type of service that could be provided given the knowledge and demonstration base of the last 10-15 years?'

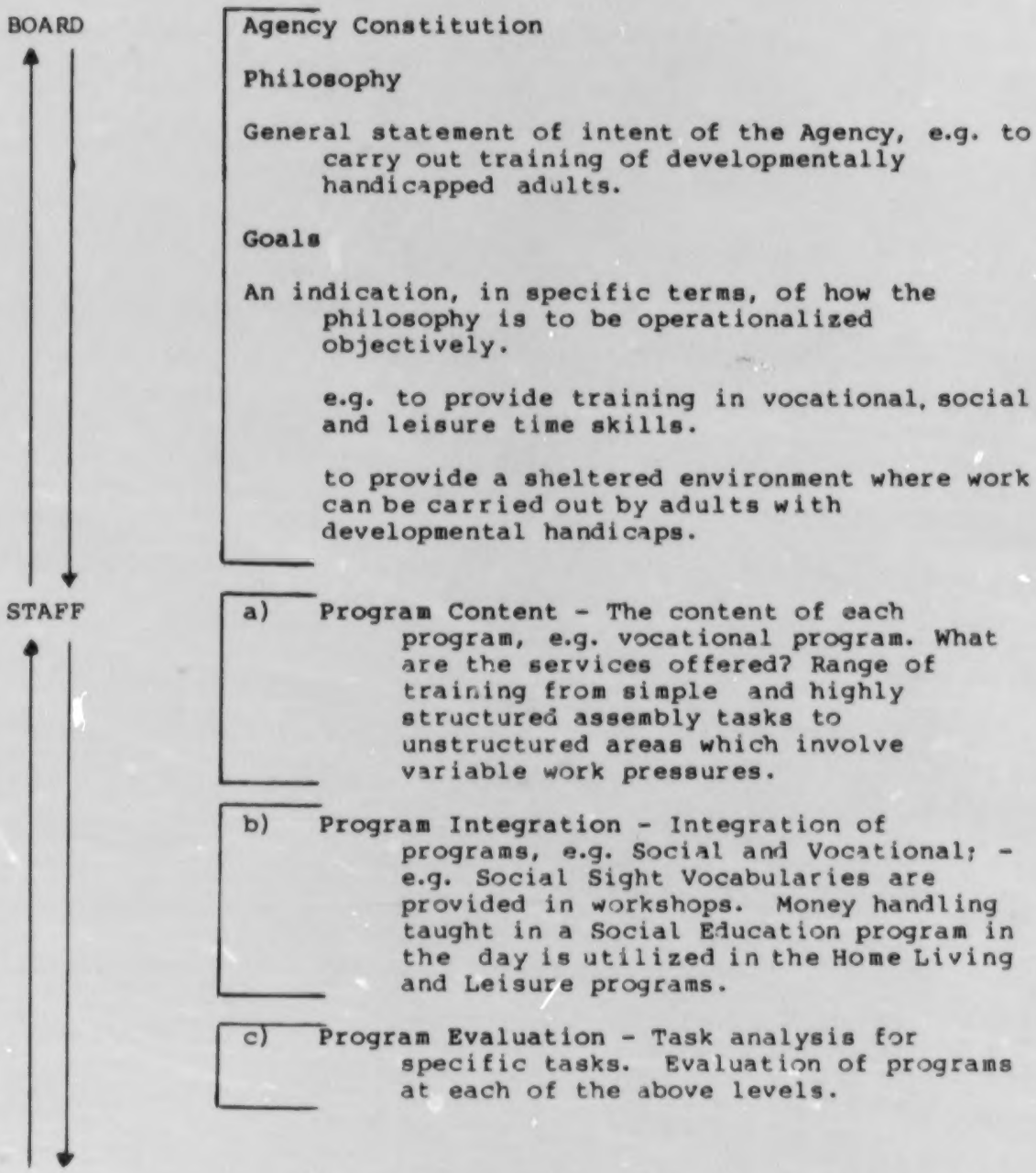
Although we must recognize that leadership is a critical component in the development of any agency, we would do well to examine those qualities which makes centres a success or failure. Although I shall return to some of the issues of personality at a later stage, I want first to look at some of the structures which are important in the development of boards and the role of staff within those agencies.

See Figure 1

First, boards are responsible for ensuring that the constitution of the agency is formed and developed and in the case of an ATC that the personnel are responsible for a statement of philosophy. Such statements must be put into effect at a practical level and regularly updated. If we accept that senior

FIGURE 1

Philosophy and Program Integration


BOARD
Agency Constitution
Philosophy
General statement of intent of the Agency, e.g. to carry out training of developmentally handicapped adults.
Goals
An indication, in specific terms, of how the philosophy is to be operationalized objectively.
e.g. to provide training in vocational, social and leisure time skills.
to provide a sheltered environment where work can be carried out by adults with developmental handicaps.
STAFF
a) Program Content - The content of each program, e.g. vocational program. What are the services offered? Range of training from simple and highly structured assembly tasks to unstructured areas which involve variable work pressures.
b) Program Integration - Integration of programs, e.g. Social and Vocational; - e.g. Social Sight Vocabularies are provided in workshops. Money handling taught in a Social Education program in the day is utilized in the Home Living and Leisure programs.
c) Program Evaluation - Task analysis for specific tasks. Evaluation of programs at each of the above levels.

Reprinted from: Brown, R.I. & Hughson, E.A.(1980) Training of the Developmentally Handicapped Adult. Springfield: C.C. Thomas.

staff are responsible for the day-to-day running of the operation, the design of programme content and its application, then we must come to two central conclusions. First, that there is a continuum of activity which involves boards and all staff. There is no black and white demarcation between philosophy and application and it is only when a board is knowledgeable about the staff as well as the agency's aims that it can be effective and support the director and senior management in operating the centre. Likewise, it is only possible, when the staff understand the philosophy and can link that philosophy to programme content and eventually to delivery of service to individuals, that the philosophy can be tied to the day-to-day running of the operation.

Second, there must not only be a continuous change process in the programme but there must also be a continual updating of philosophy. Therefore it is wise that agencies, both at board and staff level, ensure that there are regular evaluations of philosophy and programme content - once every one to two years. My own view is that though it is absolutely necessary from time to time to have external reviews of philosophy and programme, quite frequently these are not done by personnel competent in rehabilitation practice and programme policy and therefore such reviews tend to do more harm than good. It is only when the staff are responsible and given the opportunity to evaluate their own programmes that they can become aware of deficiencies . So often deficiencies in an agency are blamed on management and 'distant' committee personnel, when in fact the responsibility is jointly that of staff, management and board. This also applies to the creation of an effective 'atmosphere' by board and senior management.

Staff will not see or recognize all the changes necessary. There must be some form of advocacy by, and on behalf of, the clients, for change. For example, clients can have a position on a board, be urged to form their own committees, be encouraged to arrange conferences, be involved in extended interviews about the programmes, and be asked what are the positive and negative features of the programmes and where there needs to be clarification of goals and attitudes, ex-clients can be asked to report on their perceptions of the agency. Obviously this makes sense in terms of normalization both for staff and clients, for we wish to encourage independent decision-making and the opportunity to learn and reinforce positive self-image and independence. Elsewhere the problems associated with self-image and self-assertiveness have been recorded, (Ryba & Brown, 1979). The author has noted in recent years a number of instances where clients have come forward at committee and board meetings and asked for changes in the nature of an organization both through its name and through its practice. The enabling concern of staff and management personnel to permit this dialogue to continue and develop is an important aspect of rehabilitation.

Selection of a board or advisory committee

The selection of a board or an advisory committee is an important aspect of any agency's function. It is one of the means by which reality is imposed on the agency and provides a specific framework for promoting and, to some degree impartially, evaluating that agency's function. The selection of board members is critical. Obviously there should not be too many. Experience suggests that between 9 and 15 is probably an appropriate number, but there must be requirements for regular attendance and dismissal of a board member, if they miss more than two or three meetings without reasonable excuse. The presence on the board of persons expert in the function of the agency is important. Availability of a lawyer, and businessmen, along with a couple of people who themselves suffer handicaps, is critical. In the case of people with handicaps, this is not to suggest any form of tokenism. The person selected must be well balanced, able to contribute, and must be sufficiently forceful in personality that other individuals are going to listen to them with respect.

New board members should be oriented to their functions. For example, they should have a clear knowledge of the agency and should be intimate enough with its running to recognize the common problems and the assets which exist. A slide presentation of an agency activity, statement of philosophy and short and long term goals is relevant, and board members should be encouraged to visit the agency on a regular basis. However this should only be done with the knowledge and consent of the executive director or manager. Some boards include their executive director as a voting member of the board and there is much to be commended in such an arrangement.

Boards should always have an executive committee. It is amazing the number of boards which function as a whole without leaving some of the more detailed and intimate aspects to a small working committee. Confidentiality, problem solving, dealing with stress faced by the director and other senior colleagues are all part of this committee's role. I generally recommend that one other senior colleague in addition to the executive director should go to such meetings. This is an important function because quite frequently an executive director or manager can become isolated when he is the only representative to such a committee. Furthermore he can become a bottleneck between the free information that should travel between board, advisory committee and staff, and vice versa. In addition, there is the ability to consult and advise and to discuss developments in the agency from a relative point of view because at least two people are in the position of discussing the issue, rather than from an absolute position which tends to be engendered if only one person is in the key position to direct developments.

A board should be a working board and each member should be involved in one or more committees dealing with different aspects of the functioning of the agency. An assessment committee is

usually one of them. Unless it is an extremely small agency this should be a professional committee. There must be a clear demarcation between philosophy and the development and application of programmes. The board is responsible for the development of philosophy, the executive to see that that philosophy is being put into effect, and the management committee made up of senior staff, responsible for the day-to-day running of the agency and for bringing forward recommendations to the other committees.

There is a tendency for parents on boards to by-pass the executive director. This should not occur. Parents must be able to recognize their different roles: as parents of people in the agency, and as independent and impartial board members. The executive director or manager and chairman should be quite clear what type of issues should and should not be discussed at board meetings.

Very often board members can deal in general terms with communication issues with the public, but it should only be the executive director and chairman who talk to the media. Staff members should know that they can take issues directly to a member of senior management and have the right to appeal beyond this if events require. A good executive director's door is always open to staff, and of course this is one of the reasons why agencies should not be allowed to become so large that this is no longer possible.

One of the simple ways of getting staff and board to recognize each others' views is to provide a simple basis for recording attitudes. My colleagues, Marlett and Hughson, in their Rehabilitation Programs Manual (1977), produced such an evaluation form. As a consultant I frequently use it in order to elicit information from staff and boards and to provide a basis for counselling board and staff, thus helping them to decide on integrated and effective procedures to adopt in order to assist their agency.

See Figure 2

Very often, board and staff members believe that each has, as a group, a common philosophy. Different views are perceived as being held by the other group. In reality, the responses frequently show wide variation amongst board members and often wide variation amongst staff members. Sometimes there is greater intra-group variability than inter-group variability. On several occasions where agency advisory committees or boards have disagreed with staff development and function and there has been a confrontation, it has been necessary to demonstrate separately to board and staff that their own in group variations are greater than the differences between board and staff. The fact that there is confrontation on these issues, and that they can be resolved, should be perceived as a positive feature of philosophy and programme development. Without putting forward and discussing viewpoints, agencies tend to become stagnant and not

FIGURE 2

Value Priority Scale

Personal Priority No.	Program Priority No.	Value Statement
_____	_____	- Education of Community
_____	_____	- Training through normal means
_____	_____	- Safety and health
_____	_____	- Family atmosphere
_____	_____	- Research
_____	_____	- Specialized and individual training
_____	_____	- Efficiency
_____	_____	- Friendship within peer group
_____	_____	- Clean, sanitary surroundings
_____	_____	- Normal rhythm of life
_____	_____	- Instilling discipline
_____	_____	- Family involvement
_____	_____	- Continuum of services
_____	_____	- Independence of client
_____	_____	- "No nonsense" atmosphere
_____	_____	- Community exposure
_____	_____	- Staff development
_____	_____	- Mastery of skills
_____	_____	- Protection of society
_____	_____	- Integration with non-handicapped

Reprinted from: Marlett, N.J. & Hughson, E.A.(1977) Rehabilitation Programs Manual. Vocational and Rehabilitation Research Institute, Calgary.

to look at innovative means of bringing together a programme or pursuing new ideas in rehabilitation.

It is in these conflict situations that the outside consultant has a crucial role, not primarily as evaluator so much as recorder and counsellor, for it is his or her aim to provide the board and the staff members with information in order that they can decide on the philosophy they want and therefore design programmes which fulfil that philosophy. There are many examples of this not occurring, for example the parent organization which maintains it is there to develop services for youngsters but does not provide advocacy for youngsters' programmes. Yet many of the recommendations that are necessary relate to some basic modes of operation and of thinking. For example, it is important to obtain views on individual staff's reaction to innovative programmes. Beck-Ford et al. (1984) have illustrated elsewhere how staff frequently see a new programme in a negative light because it means more work, or because they do not understand the philosophy behind it, or because they fear they do not possess the skills to put the programme into action. Many of these difficulties relate to the concrete nature of thinking that is shown by staff members rather than the forward looking and planning procedures which are also required for the development of programmes. As someone said at this workshop, we are more interested in techniques than we are in ideas. Unfortunately this is only too true and it is what makes rehabilitation a technology rather than a professional area of performance.

However, individual managers should be made aware of the importance of some of the minor issues within their agency. For example, the type of tables used for discussion, often long tables with chair persons sitting at one end,are totally inappropriate for the type of round table discussions that are necessary. Areas for relaxation are needed where staff can sit comfortably and discuss with one another why they believe programmes are built in certain ways. Frequently there are underlying emotional issues which are critical to the development of a coherent programme. Managers should make it possible for such discussions to take place and should frequently involve outsiders who are capable of leading unbiased discussion rather than rely on the presence of a manager whose views are frequently only too well known.

Parents and agencies/centres

Quite frequently parents and others are not in a position to know what type of questions to ask staff and thus have to be assisted in this task. For this reason we have found it beneficial to ask parents what they perceive to be the possible requirements of programmes, what they feel their youngsters have got out of programmes, and what life issues are involved in the development of programmes. Frequently we have found this is 'ammunition' for parents to use in an agency to gain knowledge and insight into the programme. Knowledgeable, concerned and advocating parents are essential if we are to develop helpful

services. Because of this an advocate has the role of interpreter and question provoker, not putting words into the individual's mouth, but because they know the agency well and because they know the needs in rehabilitation, they can enable parents to provide pertinent questions which will help in the development of programmes for their own youngster.

Programme integration

One of the major difficulties in most rehabilitation agencies is the fact that they deal with diverse aspects of an individual's functioning - vocational, educational, social, leisure, home living. Whilst the basic principles, concepts and rules are much the same in each of these areas, departments tend to operate in isolation. Because the various behavioural areas are dealt with at different times of the day, we act as if an individual's behaviour is composed of discrete and unrelated parts. In short, we unnecessarily fragment performance, behaviour and the individual. Residential agencies are often separate from vocational agencies. Leisure time programmes are separated from both. Sometimes they are run by the same organization, but generally under a different director and with different staff. Thus it is not surprising that staff come to different conclusions about the individual and try to run programmes which are antithetical in terms of the individual's learning processes. The ability to coordinate and integrate the programmes in a concise and structured fashion is frequently absent. Yet our clients are the very people who require structure and consistency. Many times I have seen individuals taught different reading techniques on the same day by different staff and different organizations. I have noted staff in one programme who believe an individual can be rehabilitated while other staff in another programme, believe the same individual will never be rehabilitated. I have seen agencies which believe in integration, work beside, but not with, agencies which believe in strict isolation. It is of immense importance that programmes are coordinated.

There are a number of ways of doing this. One is to ensure that senior personnel who look after one programme are also responsible for other programmes. Thus a director of programmes is required, though this is often seen as anathema to those in the business field who believe that different operations should be under different directors. If the agency is reasonably large (say 100 plus), it may be desirable to have two or three directors dealing with all aspects of an individual's integrated programme, but only being responsible for about 30 to 40 clients altogether. In other words, the relationship, in terms of direction, should be across programmes for specific individuals rather than for a large number of individuals in one type of programme. This also has greater efficiency in terms of staffing, for opportunities then arise for individuals to move from one aspect of a programme to another. Thus, individuals who may be suffering stress or burnout, or be unaware of provision of programmes in other areas, obtain opportunities for learning,

experience, and sometime recovery within facets of another programme. Of course, this model does not lend itself to some of the administrative arrangements that agencies like to see, but it is a means of dealing with the individualization of programmes that is so critical within the rehabilitation field.

Ethical issues

As a consequence of the community's greater awareness of the need to monitor and control the treatment of handicapped people, a number of ethical issues have come forward over the past few years. It is therefore essential that any agency working in this field in the area of research and demonstration should have an ethics committee. However, there will have to be some clear guidelines in terms of what the role of an ethics committee should be, now that many agencies are establishing committees as a result of the Helsinki agreement on human experimentation.

It is not the role of an ethics committee to say whether research is worthwhile or not. Many ethics committees have tended to destroy and do harm to the development of research. For example, keeping names anonymous at all levels and destroying records after research is completed, are undesirable actions. It is only when the research worker knows with whom he is working that the research becomes meaningful. It is then that the research worker becomes concerned about what he is doing with individuals and for what purpose. In a recent example research workers were requested to destroy the names of clients and reference numbers when they had completed their study. This made it quite impossible to investigate possible sibling interaction or later follow-up of clients when some key questions were posed regarding relationships and development over time.

Training centres should also become concerned with the application of particular procedures, such as restricted practices in the treatment of clients. The need for a therapeutic committee to look at procedures that are used within a centre is extremely important, for this is one means whereby not only abuse, but inappropriate application of knowledge can be dealt with. Once again this relates to the knowledge base of the personnel and underlines the concerns noted in a later paper in this workshop report regarding changes in the future of rehabilitation. It is important that individual staff members comment on what they think is appropriate in terms of research, and the model used by Whelan whereby staff representatives suggest worthwhile research topics is laudable. However, it is also essential that important projects are not stopped because of the limited view of particular field workers. For example, a recent piece of research relating to fine arts was prevented because individuals considered it did not represent core research and that there were more important things to do at the agency. The same problems have arisen around the leisure time programmes that have developed. The staff have declined to invest in particular aspects of leisure time on the grounds that it is not of top priority, (see Beck-Ford et al., 1984).

Involvement in these issues can raise the general education and leadership levels of staff. Further, an agency that does not have an in-service training system to discuss these issues does not encourage knowledge to be in the hands of all staff. Such gains in experience and application should be linked to salary, both in terms of formal study and promotion. Further, staff must be selected because they have drive and enthusiasm. If they do not believe that rehabilitation can occur, however slowly, then one must question why they are functioning within a particular agency. Such matters should form part of initial and follow-up interviews with staff throughout their employment period.

Cost effectiveness

Cost effectiveness is a major challenge to agencies. It is difficult to understand or to calculate how effective a particular programme is. Costs are not kept very adequately in most programmes, and financial printouts are ill-understood by the majority of staff, often, one suspects because of a lack of opportunity. It is important, however, that staff have an understanding of the costs of running a centre, not least because they can often suggest ways in which savings can be made. Unfortunately, very often this is done at the bureaucratic level, distant from the agency running the service. It is apparent from recent studies in Canada that quite a lot of funds, which are employed in the running of services for handicapped persons, are not clearly identified in terms of the actual contribution they are making. One suspects that greater cost effectiveness could take place in this area.

Very often boards will ask whether a programme is cost effective. Again,it is impossible to give an answer to this for in many instances one does not know whether a particular project is programme effective or who it will be effective for, or for how long. This raises the whole issue of long term study and development, for without long term aims it is unlikely that effective strategies will be developed within the rehabilitation field. It is perhaps of interest that we have tended in the past to attempt to predict who will be successful and who will not be successful in terms of rehabilitation. It may be of more interest to correlate outcome, and therefore prediction, with the nature of the programme that the individual attends. In other words, it seems quite possible that given people have handicaps, that whether or not they are remediated depends on the quality of the programme, not the limitations of the individual.

Large organizations are said by some to be cost inefficient, and yet there is enough literature to show quite clearly that this still remains in doubt. Some of the moves towards integration, and the wider movement of normalization, have assumed that these changes will be cost effective steps. But that really is not the issue, for normalization is not a way of saving money. Further, the monetary issue is confused by extraneous non-related procedures. Because of this, in many places - Ontario in Canada is an example - funds that were saved

by the closing down of large institutions were not, as first intended, put into the development of appropriate services in the field. Thus normalization degenerated into a dumping process and not a true test of whether individuals could be integrated into the community. This of course leaves us in the position where politicians and others regard the process as one of rehabilitation failure on the part of handicapped persons, when in fact the fault lies with the mechanisms that we have provided. Yet there are simple but effective ways of demonstrating cost savings. For a number of years we kept details of income tax paid by ex-clients and sent the results to the Minister of Social Services and Community Health. The impressive data made its way to the floor of the Legislative Assembly in record time!

Issues of agency size

There are a number of issues which arise in relation to the size of particular agencies. We have, in most Western countries, recognized the need for coordination of services and have tended to put them under massive government control and bureaucracy. This of course is a system that goes in cycles, with ebb and flow between private ownership and direction on the one hand, and government control and administration on the other.

Where there is a large agency serving more than 100 to 150 clients - and remember many of our administrative bureaucracies deal with thousands of clients - the following would seem to occur. Senior management personnel in the bureaucratic systems come to know little about programme needs for the clients that their service endeavours to help and nothing about the individual clients whom their agency serves. Because they have no control over these critical aspects or liaison, they set up administrative bureaucratic systems which provide checks and balances of a written kind.

The impact of this is that services remain inflexible because of the rule systems which are developed. Indeed the amount of written material appears to grow exponentially in relation to the size of the agency. It is impossible to meet individual needs and requirements and the service is very quickly directing its attention towards the management needs of senior staff, some needs of frontline staff, and few needs of clientele. The possibility of making changes based on demonstration generated from ideas of frontline staff or the application of research findings is remote. This partly relates to the size of the system, but it also relates to the people who move into administrative networks who find little time to update themselves in terms of procedure and knowledge. Frequently their observed motivation is for control rather than for delivering an excellent frontline service. A rotation between administrative and mid-programme management might reduce this concern.

These comments are not new, and for a long time have been recorded in a range of literature, (Schulberg & Baker, 1979). In

addition, the development of advocacy and the People First movement, and of course, in the United States, parent advocacy have developed tremendous pressures on special education systems, (Sarason & Doris, 1979) and have had a profound effect on programmes. Whelan and his colleagues have attempted to involve frontline staff in decision making processes and in the development of research and have noted the motivating effects of this procedure on staff. The problems that this can occasion when the evaluation becomes critical of the system that is under evaluation have also been noted. Frontline staff find it very difficult to accept criticism - direct or implied.

A further problem associated with this system is that the more able people who have got frontline experience are always promoted, either to areas where they have little frontline impact, or into universities and colleges where they educate the next generation of educators. The only problem is that many of us, once we are out of the practical limelight, may stimulate colleagues in terms of ideas, provide and evaluate information, but are no longer at the cutting edge of the rehabilitation process. Such personnel must preserve links with community agencies. How is this to be done?

The training of administrators and managers

During the last three or four decades it has become particularly fashionable to ensure that the senior person running a particular group is ignorant of the business of the group that is being run! That is, we believe that we should have qualified administrators who have had no education or health experience at frontline and programme levels. It is not seen as necessary even to have a general knowledge of the services which are provided. Direct services are delivered by a different kind of professional. What we require, we are told, is some person who will look after the business side of things. Although there are obviously many well meaning people in this area, it seems to me the professional administrator, who has not been trained in detail in the business of the agency, cannot readily promote an effective organization. I realize such a view is neither fashionable nor popular. My argument is not against there being professional administrators, but against there being administrators who are just trained as administration professionals.

Administrators not only need to know the business of rehabilitation, they also need to be highly skilled in the areas of counselling. A progressive agency has many problems which run from the rumour mill and the stresses associated with burnout, to the extreme views of a few members of staff and the wide range of personal problems which interfere with the smooth running of an agency. These are not disasters, they are not events which should not be there, they are the natural ways in which human beings perform, and therefore it is a function of administration to deal with these as professional counsellors. This also says something about an administrator's knowledge base.

Further, the range of personnel who are often selected to supervise and to evaluate projects in the educational and health areas speaks to a proliferation of concern. We tend to appoint lay persons who can then be regarded, in terms of specific professional functions, as impartial. It has not apparently crossed people's minds that impartiality is sometimes a synonym for ignorance.

I believe we require an increase in the number of professions within the rehabilitation area and a change in attitude to boundary disputes. For example, we need a breakdown of the current teaching model which says that only people with teaching diplomas or B.Ed. degrees are qualified as teachers. We must redefine teaching and it must include the wide range of social, leisure and allied pursuits which are so important in the development of learning and quality living processes for handicapped people. We need more transdisciplinary integration, but we also require new professions, as new knowledge needs to be bound or gathered together in innovative ways to advance the level of rehabilitation.

Administration management/leadership style

One of the problems that has been overlooked over the years is the nature of leadership style and the development of creative ideas. It is probably a truism to say that authors of psychological and educational work find that their advice and procedures work better in their own hands than anybody else's. For example, reading techniques which have been placed on the market in the last 25 years often show in their study manuals, considerable increases in attainment by those who have been subjected to the programme. Quite frequently later work shows that when the material is employed by others, the results are less impressive. Although there are those who feel that individuals are biased in relation to putting forward data on their own programmes, other explanations are also possible.

The first of these is that individuals, in writing up research and programme procedures, do not tell us the key aspects which are relevant for replication. In other words, we have a somewhat distorted idea of what is necessary to communicate when we are advising people on the content of a programme. Secondly, the style of leadership that is generated may be critical. An enthusiastic person who gathers around him/her a large team of staff who, in their own turn, collaborate and work together are likely to generate so much enthusiasm amongst their clients that the individuals are likely to succeed regardless of whether they are given a good programme or not. It seems likely from our knowledge of motivation and reinforcement theory that this type of social modelling of enthusiasm is a critical feature for the development of a high level of activity amongst handicapped persons. This is not to say that any old programme will do, but it is to suggest that a good programme in bad hands is not likely to work, but that positive results may be had from good hands who have in their possession a poor programme. This is an

important area of research for the future.

Management issues in rehabilitation services

In rehabilitation we generally train people to do specific jobs and to teach in a particular fashion. We provide certain skills and require that the individual relates to other personnel in a specific manner. Rehabilitation, by its very name, implies change by the client who will need different resources and different inter-personal relations as he/she develops and changes. Indeed this will mean a change in behaviour and a change in style by the person who is the educator.

We have suggested elsewhere that individual staff need to change from acting as a director of a client's programme through to an advisor, and finally to an observer as the client develops, (Beck-Ford & Brown, 1984). That is, the best type of rehabilitation worker will have a range of styles which can be employed within the educational situation. Of course, this implies considerable insight into one's behaviour and a recognition that one does not, if one has an authoritarian or a laissez-faire type personality, simply project this personality into the learning situation. One does need to have sufficient insight and control to modify one's approach and match it to the stage at which the individual has learned to perform. This must mean a totally new approach towards the training of staff. It involves not only the teaching of fundamental skills in terms of learning strategies, but a flexibility on the part of students to enable them to role-play a variety of situations as the need arises. They must be aware of the need for style change and thus the need for continuous monitoring. They must be efficient in direction and must be able to reduce their role to that of advisor and observer. And, of course, they will recognise, since individuals advance and regress, that they need to be flexible in this approach over a matter of a few hours. Yet this must not be so random and so variable that a loss of structure occurs for the individual client. It is important that clients learn to predict who is reliable and who is not.

It means that staff in various programmes must be aware of their limitations and must be able to pass their clients on to other staff who at particular stages can more easily meet their needs. Whilst these issues are a matter of concern to me, my greatest concern is my ability, or lack of it, to relate to people as a manager or administrator when an organization grows too large. Until the Vocational and Rehabilitation Research Institute reached about 100 clients I knew, as Director, the details of the majority of clients sufficiently well to know how each was progressing. I could walk around the agency with the senior placement officer and ask what progress staff had achieved with particular individuals. In other words, as a leader I could act as a catalyst, because I knew enough about individuals to know roughly where they should be or what their problems were likely to be. I also was able to know the staff sufficiently well that I had some feeling for whether they were working

adequately, appropriately, whether they were learning, whether they were trying new methods or not.

Once an organisation becomes large, one has to rely solely on people's verbal information. But we all know that verbal information is distorted, whether it is written or given in oral format. I am not suggesting that staff go out of their way to deceive, but I am saying that we have not yet applied one of the most important pieces of psychological knowledge - that when we observe stress within a particular organisational context we are forced into a visual method of reaction and problem solving. The administrator at a desk is bound by oral and written information which is always very ineffective in problem solving.

Staff-client relations: some dilemmas

I was brought up in an era in which the medical model of staff-client relations was seen as the ideal one. There was a distance between one's clients and oneself and one was there to deliver a service bereft of emotional contact other than an empathizing and understanding relationship. But then that model related to physical problems shown by the individual. The complexities of social transaction and the part this plays in psychological physical health were not recognized.

As workers in the rehabilitation field, we are concerned with psychological, educational and social issues as well as issues of physical health. This must force us to look again at the types of relationships that are engendered between professional staff and their clients. Understanding and empathy are important, but other emotions are often involved in relationships which by the very nature of rehabilitation tend to be maintained over a considerable time period. Staff quite frequently act as substitute parent figures or friends.

I remember being told as a student that I should not accept gifts from clients. I think of some of the questions plied to psychologists at oral examinations in my own Province of Alberta,which relate to what one should do if one has sexual feelings for or receives sexual advances from a client. The answer in most of these situations appears to be to have insight but run away! But this message can be a damaging one to the client. Frequently both young females and males who come from abusing families or from no family at all, require the supports and structures which become the motivators not only for learning but for the building of a positive self image. These developments are not based just on professional empathy, but on affectional and loving ties. I do not know the answer to such situations, but believe the professional workers should be aware of these processes, not ignore them nor substitute somebody else who will question the relationship. There should be someone who will accept the situation as a representative of societal care for that individual. That may mean accepting gifts. It may mean receiving, giving and making affectional bonds. But then one

must be clear what is occurring, mediate these appropriately and ensure that the person can grow and build acceptable social relations within a professional context as a result of the security and structure of such bondings. In relationships there must be room for people to grow and move on. But remember also, staff move on and leave their students. This must be prepared for.

Another important aspect of affectional bonding is between staff and this will occur particularly where there is a strong sense of purpose and common goals. What responsibilities does a manager have for the impact of an agency on a staff member's family?

Stress and burnout

Perhaps this naturally leads me to talking about the nature of stress and burnout within staff. On the whole burnout is viewed as a gradual process, and generally the person is typically unaware of its onset. A number of symptoms have been described as associated with and part of the syndrome of burnout. Some of them are: frequent headaches, gastrointestinal disturbances, exhaustion, and lengthy recovery from colds. Psychologically they include quickness to anger, rigid thinking, inability to control emotions, feelings of paranoia, depressed appearance, more energy expended with less accomplishment, (Mendaglio, 1982). Maslach (1978) regards it as a gradual progression and an inability to deal with emotional stresses of the job with an end result of low job morale, high absenteeism and job turnover with a loss of idealism, energy and purpose. Typically the individual's non-work life situation is also affected. Problems in the work setting may be displaced to personal and family relationships. Marital friction, for example, is likely to increase. Particular individuals are unable to recognize that they are mistakenly attributing sources of friction from one situation to another. They may withdraw from colleagues, particularly in areas which are regarded as requiring optional interaction.

From the institutional point of view, absenteeism, staff turnover, reduction in productivity, are all characteristics of burnout. Where there is job stress there tends to be the seeking of higher salaries, and generally a seeking of tangible concrete rewards for the particular job. Maslach has cited burnout as a major contributor to poor health care delivery services. Dehumanization of the client, and recipients recognised by their labels rather than as human beings are symptoms of this condition. Unfortunately burnout has been noticed in those who come to a service with strong idealism.

Burnout may be affected by role ambiguity, for example, lack of a clear job description, role overload, and expectations of a caseload which the individual does not believe he can cope with effectively. Emotional involvement between the client and the staff member can be a further area of concern. It is also noted

that those suffering burnout tend to believe that they can cope extremely well, do not need the help of other people, and believe that the work that they are doing cannot be done by anybody else.

Summary

Perhaps this is a fitting place to end this paper but before doing so I would like to summarize the main points made:

(1) There is a crisis in management rules and behaviour which prevents the development of innovative and effective services.
(2) This relates to a lack of clarity of:
    (a) agency philosophy;
    (b) programme goals; and
    (c) job descriptions and expectations, which in turn relates to programme structure.
(3) These problems occur at board/management/and staff levels. Changes are required at governmental and agency levels.
(4) There must be frequent philosophy and programme reviews.
(5) There is a need for programme integration as part of this philosophy.
(6) Each agency needs an executive or advisory committee.
(7 Ethical issues should be discussed by staff and procedures outlined.
(8) A realistic long-term approach should be taken to cost evaluation.
(9) Agency size should be examined in terms of ability to deliver an individualized programme.
(10) There should be frequent agency evaluations. This should be a shared board and staff function.
(11) Administrators and managers should receive education in their roles. At frontline as well as at management level, education and experience is required. Leadership style is critical and is worthy of further examination.
(12) Rehabilitation is a transdisciplinary area and should give rise to new professionals.
(13) Directors should manage a limited number of clients but be responsible for all aspects of client's programmes.
(14) Job stress is a major concern and its remediation must involve skillful counselling by managers.
(15) Relevant persons (parents/students) need advocate support in asking questions of agencies.

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THE ROLE OF THE VOLUNTARY SOCIETY IN CANADA

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Introduction

My knowledge of the role of the voluntary society in Canada has been gained through observation and experience. I am not aware of any educational courses on this topic for human service professionals, and perhaps this is an important omission. Certainly, my five years as an employee of a voluntary society has provided me with a wealth of experience and, hopefully, some understanding of the importance of such organizations.

Are my experiences in Vancouver relevant to your situations in England? While I am sure that there will not be an exact correspondence between the roles of voluntary societies in our two countries, it seems likely that many of the issues will be similar. Consequently, it is my intention to use a typical Canadian voluntary society as an example, and to later invite your comments on its similarities and differences to such organizations in Britain. Nevertheless, I think it may be necessary to focus initially upon some of the larger similarities and differences between the two countries.

Major geo-political factors

To begin with, there are some important similarities. Canada operates on a British parliamentary system, we share a common Head of State, and, as a former colony, Canada shares much of British history. In contrast, Canada is a country of immense size, while Britain is small. Many of you live closer to Eastern Canada than I do, my nearest federal MP in power is over one thousand miles away, and my neighbours and colleagues in Calgary can be reached by road in a mere 15 hours - barring avalanches and mudslides in the mountain passes. Conversely, Canada has a population which is only about one-third of that of England and Wales. There is a northern frontier with its boom towns and frontier mentality. To fly into these communities is an awesome experience. However, one is never sure whether one's heart is racing due to the magnificence of the landscape, or doubts about the sanity of the pilot.

Language is a major issue. Canada is officially bilingual and there is a strong French cultural influence especially in Quebec. Many other languages are spoken in this multicultural country and even the English is somewhat different from that spoken in Europe. For example, an immigrant doctor from Scotland received many shocked glances from her patients when she said, "Keep your pecker up!" In Canadian slang, "pecker" is a synonym for penis.

The Canadian political system as it effects human services

In Canada, there are three levels of government, namely the federal, provincial and municipal authorities. The federal government focusses on national concerns, such as employment, immigration, and fisheries, while each of the ten provinces is responsible for its own departments of education, health and

human resources. However, there is a complex cost-sharing agreement by which the federal government provides substantial support for provincially-operated social services. Municipal governments have the least power, and are responsible largely for local transportation and land use legislation.

Local AMRs in Canada

Local associations for the mentally retarded (AMRs) are among the most numerous and active of voluntary organizations in the country. Paradoxically, most no longer retain the words 'Association for the Mentally Retarded' in their titles, although the acronym 'AMR' remains. Due to the lobbying of consumers, AMRs currently have titles such as 'Association for Mentally Handicapped People' or a name which omits mention of any kind of handicapping condition. The relationship between local societies is that of a 'grass roots' movement. In each geographical area, these locals combine to elect and direct members of a provincial body. The provincial AMRs, in turn, sponsor the Canadian Association for the Mentally Retarded.

The National Institute on Mental Retardation (NIMR), the educational wing of the national association has exerted a major philosophical influence on the field in the last decade. In the early 1970s, Dr. Wolf Wolfensberger was invited to the Institute as a Visiting Scholar, and his resulting publication, "The Principle of Normalization in Human Services" is now widely accepted as an authoritative statement on service delivery to devalued people. Intensive workshops on the practical implications of this philosophy (PASS, PASSING) have been held across the country, and, at the local AMR level, have raised consciousness and influenced decision making.

Vancouver-Richmond Association for Mentally Handicapped People

My employer, the Vancouver-Richmond Association for Mentally Handicapped People, is one of the largest AMRs in Canada, currently serving some 600 people. It has been tagged a 'birth to death' organization for it provides a lifetime range of services which can begin in the birthing hospital and terminate in old age. The goal of the Association is to enhance the quality of life of persons who live with a mental handicap through both service delivery and advocacy.

The membership of the Association elects a 17-member Board of Directors on an annual basis. The constitution specifies that the majority of the directors must be parents of mentally handicapped people, and that two consumers,(ie, persons with mental handicaps) shall also have seats on the board. The remaining directors are volunteers in the truest sense, for they have no vested interest in the affairs of the Association. The constitution also stipulates that staff cannot be voting members of the society, nor may they serve as directors. However, the three senior staff attend all board meetings in an advisory capacity, while other employees make periodic presentations at

these gatherings.

Funding

The funds for the operation of the society's services come from a number of sources. First among them is the provincial Ministry of Human Resources. They provide overall funding for the preschool and residential programmes, and subsidize the operation of vocational services in the amount of C$1.26 (75p) per client hour.While these funds are essential, they are not sufficient to provide quality services, and thus must be supplemented by income from other sources. The plight of vocational services illustrates the inadequacy of government funding. Government grants remain the same whether the society offers adult daycare or an intensive vocational training programme in food services or janitorial work. Consequently, the Vancouver-Richmond Association partially funds its vocational programme with income derived from the productivity of its mentally handicapped workers. The ethical dilemma in this situation is self-evident.

Another important source of funds is the United Way Campaign. This coalition of charities and non-profit societies launches an annual fund-raising campaign, with the donations being shared among the various member groups. However, members may not act alone at other times of the year in order to raise funds by similar means. Bequests and unsolicited donations provide a substantial yet unreliable source of further income. Such income is probably related to the public visibility of a society. Nevertheless, one is always left with a somewhat uncomfortable feeling in celebrating the demise of a wealthy benefactor!

The Association's most innovative generation of income comes through its partnership with Value Village. This organization operates a chain of thrift (second-hand) stores along the Pacific coast of North America. Five years ago when they were seeking an outlet in British Columbia, a representative of Value Village met the Association's Director of Vocational Services. He said that if Value Village could use the Association's name in telephone soliciting for donations of used clothing and appliances, they would pay the higher monthly amount of C$1,000 (£600), or 50% of the profit. Fortunately, the Director of Vocational Services saw the potential value in such a relationship, and was able to persuade the slightly xenophobic Board of Directors to sign the contract.

The venture has proved to be a great success. Value Village now has three stores operating in the Lower Mainland of B.C., and the monthly payment to the Association has never been less than C$1,000. Furthermore, in each of the last two fiscal years the Association has received in excess of C$350,000 (£200,000) from this venture! To my mind, this income has meant the difference between providing basic and quality programmes in some areas of the organization.

Advocacy

At this time, it is not my intention to focus on the range of services offered by voluntary societies in B.C., but to discuss our new and expanding role in the area of advocacy for mentally handicapped people. This has taken place both on behalf of individuals and groups, with our provincial organization, British Columbians for Mentally Handicapped People, taking a leading role. While some of the cases have been highly publicized in the media, I'd like to emphasize some of the general aspects of advocacy before returning to specific examples and evaluating their outcomes. For our purposes, advocacy may be defined as: bringing political and personal pressure to bear upon various sectors of society in order to improve the quality of life for people who live with a mental handicap.

First, it is important to understand the relationship between the members of both the provincial government and the voluntary society at the elected and appointed levels. As a general rule, employees of the Association lobby members of the civil service, but not elected members of the government. It is the elected representatives of the society who would normally meet with MPs and cabinet ministers.

Figure One

THE ROLE OF THE VOLUNTARY SOCIETY

IN BRITISH COLUMBIA

LOBBYING - ELECTED & APPOINTED

PROVINCIAL GOVERNMENT		VOLUNTARY NON-PROFIT SOCIETY
Legislature)		(Board of Directors
Premier)	ELECTED	(President
Ministers)		(Executive Committee
(Cabinet)		
Treasury Board		Management Committee
(Deputy Ministers)		(Executive Director
Victoria (Executive)		(Senior Directors
(Directors)		(
)	APPOINTED	(
Regional Managers)		(Department Heads
Coordinators)		(Site Managers
Line Staff)		(Line Staff

Issues are initially raised with line staff of the government (ie, social workers), and then lobbying moves up through the hierarchy until the problem is resolved. This means that department heads of the society may meet with Regional Managers, while the highest-ranked employee (ie, Executive Director) would discuss issues at the Deputy Minister level. Often combined groups of staff and board members can be very effective in carrying the message to our seat of government in Victoria. At the highest levels, it may be rather cynical, yet realistic to suggest that matters are sometimes resolved by the payment of old political debts by members of the government.

Some rules for lobbyists

From our experiences, we have learned some of the 'dos' and 'don'ts' of lobbying. Consequently, in order to maximise your chances of success, I'd suggest:

1. Begin by planning strategy. Define your goal(s) and itemize an action plan. Review this plan on a regular basis because events can necessitate radical changes in your plans and even your goal.

2. In terms of government hierarchies, start at the bottom and only proceed to a higher level when you dont get satisfaction. However, as you proceed, keep the lower levels informed of your actions, as they may be able to bring some internal pressure to bear on their seniors.

3. Never back the government into a corner, unless it is absolutely necessary. Always allow them the room to change their position gracefully.

4. Whenever you can, make the government look good. Reinforce and publicize their positive actions. The principles of learning do govern the behaviours of MPs!

5. Unless there is an upcoming election, don't waste time in cultivating the opposition. They are nearly always supportive but powerless. However, do keep them informed on important issues - just in case the government falls overnight!

6. Attack policies, programmes and laws, but never attack people unless it is absolutely necessary. Let people know that they are doing a fine job, but with regard to the matter under discussion there may have been a small error in judgement! Remember that personal antagonism can produce a lifelong enemy of a voluntary society, and this can have a detrimental effect on the lives of handicapped people.

7. Consider employing a paid lobbyist at the seat of government. In North America, this is a respectable

position, and the role of the incumbent is well understood by politicians. Paid lobbyists arrange frequent meetings with government officials, present the views of their employers, and make sure that the concerns of the society maintain a high profile among the politicians.

8. Don't be afraid to call in political debts. Some members of voluntary societies are members of political parties, have friends who are politicians, and may have even worked on electoral campaigns. Occasionally, a telephone call to a friend in the government can produce a much quicker solution than lobbying through the system.

9. Use the media in an escalating manner. On any particular issue, begin with human interest stories, move to policy concerns, and finally discuss the role of the government. Be prepared to be misquoted and misrepresented, for sometimes members of the press are less concerned with veracity than with an interesting article.

10. However distressing it is to be the target of hostile comments and attacks against your personal integrity, try to evaluate these in a positive way. They are often a sign that the other side is feeling the pressure of your campaign and in fact, you are making progress.

Examples of advocacy by voluntary societies

(A) The Stephen Dawson case

Stephen Dawson is a 10 year old boy whose profound mental handicap resulted from meningitis during infancy. He cannot speak or walk, and he appears to be deaf. In addition, Stephen suffers from a hydrocephalic condition which requires that cerebro-spinal fluid be drained from his brain by means of a shunt. For a number of years, this boy has lived in an extended care hospital.

Early last year, it became obvious that Stephen's shunt needed replacing. However, the medical specialist in consultation with Stephen's parents decided to withhold this treatment on the grounds that it would prolong his life unnecessarily. At this time, Stephen was described as "a vegetable who is totally unresponsive to his environment". Such an assessment was challenged by some of the nurses and child care workers who had daily contact with Stephen. They found him to be rather responsive especially in terms of enjoying physical contact with his caregivers.

Eventually, British Columbians for Mentally Handicapped People (BCMHP) and the Ministry of Human Resources (MHR) took the parents and medical specialist to court on the issue of Stephen's

'right to treatment'. The plaintiffs argued that replacing the shunt was merely a standard medical procedure which was being denied simply because Stephen was mentally handicapped. They further argued that the treatment could not be classified as a 'heroic medical procedure', a legal term used to describe exceptional strategies for prolonging lives in immediate danger.

As more information came to light, shock waves ran through the AMR community. BCMHP had taken the parents of a mentally handicapped child to court! How could a parent-sponsored society do such a thing? What was the world coming to?

However, it seems to me that the action which BCMHP took against Mr. & Mrs. Dawson was a landmark in the growth of the AMR movement. They were stating publicly that parents of handicapped children, even the most loving parents, can make mistakes in taking decisions for their offspring. The courageous decision to go to court on Stephen's behalf was, of course, largely made by parents of handicapped children!

The case finally went to the Supreme Court of British Columbia. There Stephen won his 'right to treatment'. This was a decision which will have a far-reaching effect upon the lives of many handicapped people in Canada. Stephen Dawson has had his shunt replaced, and he continues to live in the small hospital where he has spent the last few years. His parents visit regularly, and the staff are beginning to work on educational programmes which will maximise his remaining abilities.

(B) Cradlehaven

Cradlehaven is situated in a beautiful rural setting some 30 miles from Vancouver. It is a small institution which is totally funded by the Ministry of Human Resources and houses approximately 25 severely and multiply handicapped children. Cradlehaven first came to prominence because of its alarming death rate. Within one year, 11 of the children died, and official sources said that this was because they were "medically fragile". Cursory investigation praised the dedication of the staff and the quality of medical attention.

However, the death rate greatly concerned BCMHP which started its own investigation into the institution. It was soon discovered that while regular staff were dedicated, there were so few of them that they could scarcely attend to the physical needs of each child. Toiletting and feeding consumed their entire shifts. In addition, the only supplement to the regular caregivers was a physiotherapist who was available for 3 hours per week! Furthermore, these children were being refused emergency medical treatment at the local hospital some 7 miles away, and therefore had to be taken another 25 miles to a large institution for the mentally retarded.

The picture which emerged from the BCMHP investigation was a vastly different one from that presented by the Ministry of Human

Resources. We were looking at an environment of the most abusive kind, one in which only the minimal needs of the children were being met. Where were the educational programmes? Where was the stimulating environment? Where were the individual programme plans? And worst of all, where were the loving and intimate relationships which children need so much?

As a psychologist, I believe these children were dying for psychological reasons. They simply had no reason to live. Victor Frankl, a Jewish Psychiatrist who survived the Nazi death camps, has written, "He who has the why, can manage any how". Why should these children continue to live? There was no reason for them to do so.

This time, BCMHP took the Ministry of Human Resources to court, charging them with negligence in the deaths of the children. The media soon became involved in the issue and inflamed passions with some rather inaccurate reporting. Radio talk shows were inundated with calls, and the protagonists appeared regularly on the television news. Unfortunately, the majority of opinion was opposed to the position taken by the group from BCMHP who were castigated as busybodies, do-gooders, and even socialists! Next, MHR withdrew its financial support for the other activities of BCMHP. Finally the B.C. Supreme Court found in favour of MHR.

This may sound like a devastating defeat for the AMRs, but was it really? Today, the death rate at Cradlehaven is much lower. The number of staff has been substantially increased, and they are now supported by a number of volunteers. The environment is much more stimulating, with brightly painted walls, large pictures, and mobiles over the beds. Children no longer lie in one place for hours on end. They are dressed, move about the facility, and are involved in a number of activities. While these changes are not sufficient, they do represent a significant move in the right direction.

Would these changes have occurred without the intervention of BCMHP? I doubt it. Consequently, what on the surface may have seemed a defeat has had considerable positive results in enhancing the quality of life for the children of Cradlehaven.

Conclusion

In closing, I'd like to comment on the importance of this kind of advocacy. Its value goes far beyond the AMR movement. On a personal level, all of us are likely to become old and/or handicapped and to be in receipt of human services. The positive impact that we have now could well be to our personal benefit in the years to come! On the other hand, this kind of advocacy is beneficial to society as a whole. If we have learned anything from recent history, it must be to be aware of the human potential for evil. While we may recoil in horror at the information about the Nazi death camps, the seeds of Auschwitz and Belsen exist in Britain and Canada.

Consider for a moment the inhumanity of the large institutions for the mentally handicapped. On my infrequent visits to these places, I am so outraged by what I see that I want to shout out that these are human beings and we are civilised people so why are we treating them this way. Instead I strengthen my resolve to advocate for handicapped people and to speak out on these issues whenever the opportunity arises.

However, I am pleased to report that our campaign of advocacy and lobbying was a factor in our provincial government's decision to close down one of its large institutions. By the end of 1984, 360 mentally handicapped adults will have returned to family-sized settings in their home communities throughout the province. As a result of their successes, the voluntary societies in British Columbia intend to continue their advocacy at both the personal and systems level.

FUTURE TRENDS IN THE REHABILITATION OF DEVELOPMENTALLY HANDICAPPED ADULTS: PROGRESS AND PROBLEMS*

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*This paper is based on work being prepared for publication on Rehabilitation Models by Brown and Hughson

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Introduction

Over the past 30 years we have seen an immense increase in the technical aspects of services in the rehabilitation field. We have also witnessed a fragmented service and a fragmented approach to handicapping conditions within the field. Services are directed towards different types of handicapped groups and different age groups are treated in a separate and different fashion. The changes therefore that we are likely to see in the future must, to a large degree, be of a conceptual nature. That is, instead of delivering a technical service, we should be in a position to devise a sound rehabilitation philosophy which ensures that we overcome some of the problems of fragmentary service and provide a much more coherent programme for disabled persons.

We are likely to see a coming together of habilitation and rehabilitation fields, and the emergence of a much more dominant social psychological approach to rehabilitation which will be backed by an effective technology,(Brown, 1984). This will fundamentally affect the training of personnel and be influenced quite dramatically by the computer revolution.

Rehabilitation will become transdisciplinary and will involve the emergence of new professionals, but even more important, it will be recognised that mental handicaps are merely one simple branch of handicapping conditions as a whole, and we shall accept that the principles that apply to one apply across the board to all these conditions.

Several major trends which have developed over the past 10 or so years will have a major impact on the development of services for the future. These trends which are philosophical and conceptual will lead to practical changes.

Integrated programmes

No longer should we think of simply having vocational or sheltered workshop or home living programmes, we have to recognize that it is necessary for these aspects of rehabilitation to be dealt with together and coordinated in a particular fashion. That is not to say that all our programmes currently do this, nor is it true to say that the bureaucratic or administrative organizations enable the most effective forms of integration to take place. Nevertheless it is true, both from an applied research point of view and from a variety of demonstration models, that these facets of programmes do require some form of integration. Generally, individuals handicapped in one area are handicapped in other areas.

What do we mean by integrated programming? Primarily we mean that an individual will receive assessment in a wide range of dimensions of rehabilitation, we then find baseline levels of performance and from these devise programmes which are of importance to each person's development. This will entail

conferences with the individual and other parties to discuss the development of such services, and it will also mean that staff from different agencies need to coordinate their programmes together in order to supply an effective, individualized programme for the student. This implies the development of the individual programme plan. It recognizes that we dare not consider people in groups, we must plan for them individually, and where possible, integrate their specific programme with the general programme, but only insofar as this meets the person's individual and social needs.

Multiple causation and multidisciplinary involvement

This leads naturally to another major development; the recognition that handicapping conditions do not result from one particular cause. For some time we have recognized that handicaps arise from a range of precipitating causes. We recognize this at all levels of functioning. We see it in the developing embryo, we recognize it during early childhood, and also during adulthood. We observe it in the constellation of problems of the individual, but we also see it within the family and the wider environmental context.

Multiple causation implies multiple intervention. It is possible to intervene at more than one level and to these ends interdisciplinary collaboration becomes of paramount importance. From a programme point of view we need to look at integration. This includes home living, community, vocational, and social educational areas. We are beginning to recognize the importance of leisure time in this configuration. Traditionally we have used special schools and classes or sheltered workshops, vocational and residential agencies to bring about rehabilitation. The need for a wide range of social-psychological strategies as well as educational strategies means the development of a much more integrated service across the rehabilitation area than has previously occurred. Medical services, which are necessarily related to disease or physical trauma, are no longer recognized as the only or primary component in the rehabilitation cycle. Once the physical problems are dealt with then it is necessary to move on to the social-psychological issues. These are, to all intents and purposes, the same in all individuals, the level of application may differ, but the philosophy and principles of intervention are very similar.

Family life processes

One major development is the recognition that family life relationships, along with self-image and self-concept play major roles in whether a disability becomes a handicap or whether it can be overcome within the environmental context. It is also worth noting that some programmes such as sexuality programmes when first started simply involved concrete information and technique, but have now moved towards a recognition that sexuality and family life education involve a family value

system. Such programmes have a much broader philosophy behind them - they recognize the relevance of abstract emotional consequence rather than pure technique. This is clearly brought out by Diamond (1977) and it is a quality which has to be developed in all programmes and is an attribute we should look for in programme evaluation.

Community rehabilitation versus workshops

The number of traditional workshops may be reduced in the future, since it now seems possible for rehabilitation to take place without involving our traditional concrete structures. For example, can we envisage rehabilitation taking place simply within the home and community environments without involving a sheltered workshop or vocational training placement? This model is an interesting one because the argument presented here is that instead of providing the traditional routes for rehabilitation - from education through vocational to leisure time - we make use of leisure and community time as the predominant means of rehabilitation. One of the reasons for putting forward this approach is that it provides a milieu in which we can deal with basic issues such as self-image and motivation. It also encourages the development of physique, deals with social aspects of living, including nutrition, and places the accent on the individual in terms of self worth. It encourages high levels of motivation and acceptability in terms of community image. In so doing the individual becomes much more acceptable for vocational employment. It may well be that preliminary vocational and social training will be required, and in some cases vocational training will still be required within an agency setting. However, the idea of moving to a model which delivers services in the home and community environment obviously has much to recommend it. Vocational training would then concentrate on the fundamentals of vocational skills and expertise rather than on social issues of rehabilitation as it does now.

Such a model may well be easier to develop in rural areas than in the traditional urban settings where facilities are already available and vested interests argue for the maintenance of the vocational or sheltered workshop. Indeed, solving rural problems, where such a delivery system is necessary for other reasons (ie. low concentration of population, lack of staff and facilities), might provide the model for solving problems of urban rehabilitation. Such a development would fundamentally affect the philosophy of, and procedures for, rehabilitation, staff responsibilities and in turn the education of staff who work within the rehabilitation field.

Vocational change

Because of the present lack of places in competitive employment we must develop a range of small industries and services in which handicapped people can work. Particular areas will be horticulture, cafeterias, restaurants, volunteer community contracts, and home management. These services are not

only ideal for urban but also for rural areas. Some of you will say that we have had these before. The development of services over time functions something like a helical spring, for although we may come back to the same point in one dimension, we will be more advanced in another dimension. Further, if we examine changes in the general community we will be able to predict what services are likely to come back into fashion and at what level. Much of the success in rehabilitation is anticipating the community's next move and applying it to the field of disability. For example, horticultural programmes, though more mechanized than they were, have now developed intensive environments and for these, very specific and basic skills are necessary. Again a wide range of the jobs carried out in the cafeteria/restaurant area are routine, and where there is a need for a small group of persons, individualized care and support can be provided. These developments are not just related to rehabilitation, but they are and can be the basis of deinstitutionalization. We are likely to see such changes outside the rehabilitation areas as unions break down and as the work of large conglomerates become automated, making opportunities for small business and service operation more likely.

Personnel changes

All of the above suggests and requires a dramatic change in the skill level of staff. In order to bring this about there will have to be major changes to professional and technical rehabilitation programmes in colleges and universities. If a field oriented service is to be developed rather than one that takes place solely within training centres, there will be a need for comprehensively trained and skilled frontline staff if there is not to be a breakdown in service. Hopefully, this will generate three and four year educational programmes in colleges and universities which will see a blending of studies in human development, handicapping conditions, educational and social practice, plus general technical skills training. Such workers could become the key personnel within any future system. Because they are field oriented, they would not be dependent on the present hierarchical model, thus the administrative liaison will have to change. Further, because they will be in the field working directly with communities, parents and interested others, they will be the only ones who will be in a position to bring in consultant advice and specialized and intensive programming where necessary. This does not mean that we should do away with sheltered workshops or other centres, but it does mean that we will need to stress them very much less.

Already in Canada community college programmes for a two year training certificate have developed, and in many ways these are analogous to some of the education programmes in the United Kingdom,(e.g. Certificate in the Further Education and Training of Mentally Handicapped People). However, beyond this, a university education programme is developing which will mean that specialists in handicapping conditions will have many more skills available to them in the field of special education than the

special education teacher. However the amount of knowledge that has now been acquired will necessitate the provision of a wide range of in-service education. Indeed it may be argued that in order to keep one's certification updated, it may be necessary for individuals to take a certain number of in-service courses every year. Without this, it is unlikely that we will see an appropriate development of such services.

Colleges for mentally handicapped persons

We are already beginning to see, both in the United Kingdom and Canada, the use of the community college or its equivalent for the development of specialized courses for developmentally handicapped persons. Hutchinson (1983) has indicated the importance of developing programmes at community college level. However, these will advance much more rapidly if the knowledge of previous decades is integrated within these new college programmes, (Brown, 1983). If this is not done there is a danger that the wheel will be re-invented, particularly in relation to social and vocational training. By providing a normalized environment for the education of youngsters it becomes possible to deal with problems of motivation and self-image as well as skill development. Similar developments are taking place in Canada and many community colleges now run specialized programmes of varying duration which deal with basic social and vocational skills. Unfortunately intelligence levels are sometimes used to decide whether individuals are able to enter the programmes rather than a much broader examination of the person's baseline performance profile. The latter must be seen as a key issue if the programmes are to be effective.

Normalization

Developments are likely to continue to take place in the areaof normalization. However, although this has been a pervasive philosophy, it has lacked, to a large degree, the application of an effective technology. This will need to be diligently applied if we are not to see a reversal of the normalization trend and an increase in re-institutionalization. At the present time a large number of people in developed countries are unemployed. Many disabled people are being, in effect, dumped within the community or left in the community without work. There are few adequate services to deal with the problems that they present. We require much more sophisticated programmes which will involve large scale and innovative placement and follow up services.

We need to be aware that people who develop late in life may deteriorate early in life. This in itself is a major research topic, and should be a concern for all civilized rehabilitation services. It is interesting that some recent data by Marlett (Calgary Census, 1984) shows an increase in the number of older people who are recognized as in need of service provision. This does not imply that we need to dump people in auxiliary hospitals for the elderly or reopen institutional wards, but that we should develop adequate community resources to meet basic needs. But

what these needs are and what services would best accommodate them remain major questions.

The future must involve developments in the area discussed above but whether such developments will emerge before the need is critical seems unlikely! This is not a phenomenon which is unique to mentally handicapped persons but also applies to a wide range of handicaps. The concern for aging handicapped persons was forecast at least 10 years ago as new vocational and social programmes were being built in Canada. But the lack of a long term strategy, the inability to see the end of 'honeymoon funding', a need for quick placement figures and crisis intervention have directed our attention away from the possibility that late growth might be correlated with early deterioration in some people, and that rapid changes in society can spell disaster for individuals who are disabled and therefore require other types of intervention services.

Much has been made of the differences between disability and handicap - but one aspect overlooked is that disabilities become handicaps when rapid or large environmental shifts take place. It is the responsibility of staff in each agency to examine the shifts that are taking place and adapt services to them. One of the most important means of dealing with such issues is to ensure competent placement and follow up services which include collection of data relating to living conditions and needs, including consulting (note this word) with clients. In this context there is need for much more effective advisory and consulting services which deal with long term programmes. For too long we have considered placement and follow up as a brief period with reinvolvement only if tragedy occurs. It is rarely seen as a life long process for mentally handicapped persons who wish to live in the community at an acceptable level with quality life experience.

Cost evaluation

Much has been written about cost evaluation and cost effectiveness. However, it is a difficult area with which to deal, (see Conley, 1973). It is generally agreed that institutionalization involving large numbers of people is not cost effective, and certainly some recent studies in Canada suggest that the large costs that are involved do not appear to go to direct programming for the handicapped youngster. Indeed it is rather unclear where the funds do go. We will continue to see a wide range of studies in terms of cost evaluation, and hopefully these will result in an interaction between management and administrative strategies in terms of client outcome.

Most of the work today does not relate to client outcome but arises from management/staff concerns in a cost-conscious society. Management models in rehabilitation are frequently changed to suit industrial or allied systems where the models may be inapplicable. I suggest this has been a major error by governments in North America believing, as they often do, that

management evaluation of service agencies should be done by people who are unaware of the particular nuances and strategies of the rehabilitation field.

Parent involvement

Some of the suggested changes will result in greater parent interaction. But parents cannot be expected to be permanently involved with support of their handicapped child. In some countries there are positive changes in terms of tax allowances for parents and nursery care support for children of working mothers. If we expect the handicapped child to live at home, then personalized resources must be brought into the home. But this again has implications for the staff training model. The normal staff hierarchy patterns cannot be used effectively in this situation. We shall require eclectic staff who can work in the community and in the home situation without direct supervision. They must have a broad range of skills in order to intervene at a variety of levels. The service will be a partnership between mother/child/and home practitioner.

If parents are going to become much more involved in the development, training and support of handicapped youngsters, then notice must be taken of the stress that this involves. In the United States at the present time, estimates of abused children range from 200,000 to four million cases annually. The report from the National Centre on Child Abuse and Neglect provides an estimated figure of one million cases per year, (Zigler and Gordon, 1982). Other authors, such as Faller and Ziefert (1981) suggest hearing losses, cleft palate, colic and other conditions are among the precipitating factors in child abuse. In Canada there is some evidence suggesting that abuse amongst the parents of handicapped children is greater than amongst the parents of normal children. Intervention at present is largely agency based yet these problems probably require direct home intervention supporting a new approach to the training and supervision of staff outlined earlier.

Education, normalization and the law

Although many people believe in total integration, the fact remains that we are likely in the short term to see a proliferation of specialized units within existing schools. Indeed a dual model is likely to develop, one involving specialized resource and remedial areas with specialized equipment and staff, and another where mentally handicapped children and adults, at least for part of the day, are likely to be supported within integrated environments with the help of specialized personnel.

Developing countries

One of the other changes that we are likely to see is a move away from demonstration and application studies, within the developed world to the improvement of resources in developing

countries. This is not just because of a natural transfer of knowledge from one place to another, but many research workers are finding it difficult to obtain funds for research within their own countries. Bureaucratic procedures have become so overwhelming and some of the ethical and professional practices relating to innovation and the practice of research so horrendous that it is easier to conduct research in the developing countries. Further, it is easier to obtain funds for working in developing countries, and this has high value in the eyes of political and economic leaders.

The idea data cycle

There seem to be cycles between the production of ideas and the generation of data. During the last 15 to 20 years we have been through a cycle where it has been seen as important in education, psychology, and social sciences generally, to carry out intensive research, collecting data to refute or support ideas. There has been much critical work of the theories and theoretical models that were developed prior to this time. One well known example is the criticism by Eysenck of a variety of psychiatric and psychological theories. Indeed many students have been brought up over the past years believing that theory formation is premature and that the need for the empirical collection of data is essential, even if this does not lead to the development of theoretical constructs. In the past few years we have entered a cycle of idea generation. We see this taking place in a wide range of fields, including that of rehabilitation. At the current time it is acceptable to put forward new models and new concepts of handicap on fairly slim evidence. Quite often the evidence that does exist comes from demonstration models, from clinical practice, or from the views of parents and other groups. Obviously there will come a time when this generation of information or model building will have to be questioned and examined at an experimental level. We will then criticize the development of these models and enter a new evidence gathering stage, rather than proceeding to the conceptualization or artistic stage. It is essential that students understand this cyclical process and also recognize that there is a validity to both processes and an interaction between them.

Development of demonstration model

In order to ensure that the knowledge of the past few years is put into practice and the research and demonstration gap does not increase, it is important to develop a wide range of demonstration centres. These centres should be associated with aspects of research and practice and should act as a resource to surrounding agencies dealing with different aspects of rehabilitation. Their management and programme significance should lie in the fact that they are there to carry out research and put it into practice. Their aim is not to carry out experimental research which is, for example, related to aspects of learning theory or fundamental medicine. This is not an

argument against the carrying out of such research but an argument for a much more effective 'research to practice' link within the field of rehabilitation .

A range of new projects

This paper has been dealing with some of the issues associated with future trends in rehabilitation, yet a large number of trends have not been discussed. Training and transfer phenomena linked with problem solving strategies such as those of Feuerstein (1979) are likely to be developed further, simply because an ability to give internal structure rather than a wide range of specific pieces of knowledge is crucial for handicapped people. This, too, will mean a change in rehabilitation strategy.

The development of processes of metacognition will go ahead particularly as we become more aware of an individual's internal processes, self-esteem and awareness. It is rare for us to ask handicapped people what they find difficult, what they find disturbing, and what they find helpful. In some of our recent work, Brown, Bayer & MacFarlane (1984), we have catalogued a wide range of concerns which illustrate issues which cause anxiety in mentally handicapped persons. Issues of death and dying, both for themselves and for their loved ones, feature very high on this list. Problems associated with need and concern for other humans also appear quite frequently and yet it is rare for us to discuss these issues or give opportunities for discussion of them with handicapped persons, particularly the mentally handicapped.

Over the years we have tended to play down certain aspects of assertive behaviour amongst mentally handicapped persons, yet McKerracher et al. (1980) have shown that those individuals who are slightly more aggressive than average amongst the mentally handicapped group tend to do rather better than the others in he group. Perhaps we should recognize that to train for assertiveness, to provide for independence, and to accept some aggression is appropriate within the field of handicapping conditions. Perhaps we are too controlling and expect people to be placid and quiet. Certainly a number of supervisors that we observed, showed that they believed the best trainees were those who were least assertive,(Ryba and Brown, 1979).

As we begin to recognize that vocational rehabilitation is not the central concern of adult training, so areas of recreation and leisure time come to the fore. The role of fine arts has been particularly left to one side, yet amongst mentally handicapped people spontaneous interests in music, drama and painting are clearly seen. Recent work demonstrates these interests, (Brown, Bayer, and McFarlane). They represent an untapped resource for the integration of handicapped people within our community,(Warren, 1983).

It has been noted that technological knowledge and skills will be required from people working in the field of

rehabilitation, and it has become apparent that both computer applications and video technology have considerable applications to the field of rehabilitation. The work of Hallworth and Brebner (1980)illustrating the modifications of computer devices and other aids for use in this field have been well documented, and Dowrick's studies on the use of video taping for the development of assessment and remedial techniques is becoming well known.

The development in Canada of the wide range of human rights enshrined in the Constitution and reflected in the legal status of individuals within the provinces is bringing to the fore many individual problems associated with handicapping conditions. The issues of euthanasia and the withdrawal of life-sustaining supports, including nutrition, are being questioned within the courts. The introduction in Alberta of the Dependent Adults Act which provides for guardianship separate from trusteeship, recognizes that individuals may be dependent in some areas of their functioning yet not in others, and provides possibilities which had not been foreshadowed 15 or 20 years ago. Yet with all these possibilities in front of us there still remains, because of political, economic and social reasons, the likelihood that we will start the process of institutionalization once again. If this occurs, it will be as a result of our inability to look to the future and make plans for changing the direction of rehabilitation and probably, most important of all, by our assuming that we know the answers without consulting with people who suffer from handicaps.

Final comments

It is relevant to bring together some of the strands that I have attempted to portray in terms of their interaction. The transdisciplinary nature of rehabilitation is likely to be recognized to a much greater degree. Some of the service and rehabilitation strands that are developing separately at the present time are likely to become more involved with one another. Environmental design with its concern for living conditions is directing our attention to physical aspects of quality of life. The social components need to be more clearly defined. In some countries, such as Canada, this is promoting new legislation or an interpretation of existing legislation which affects the integration of disabled people into the community and the conditions under which they live. Many of these concerns will have practical benefits for the rest of the community, (eg, concepts relating to guardianship and trusteeship, access to buildings, rights to employment). But none of this can happen unless there is a development of effective demonstration centres. A number of these already exist and yet they are not used to full potential, nor are there enough of them to ensure that appropriate spearheads of development are available within each large community area. The concept of a demonstration centre for every two million of the general population may seem alarming, but the need is readily apparent. Unless a specialized centre in a reasonably restricted geographical area is given the

opportunity to develop, apply and explore new approaches to handicapping conditions, then it is unlikely that we will see the integration of such ideas within local authorities. This does not mean the development of new expensive centres. What is implied is the selection and identification of existing places in terms of a new philosophy of management and administration which is client-centred and does not reflect the traditional bureaucracy which is observed in the usual range of centres.

It seems likely that the research to practice gap which appears to be widening year by year will escalate to a point where no further meaningful research can be done, because those that carry out research will be isolated from the field workers who will not have an opportunity to put the research of the last 20 years into effect. These remarks should not be misunderstood. Obviously there are places where an attempt is being made to innovate or to apply existing knowledge. The criticism is directed to the fact that there seems little coordinated means in many countries to applying such knowledge on a consistent, meaningful and structured basis. Of course this all implies dramatic changes to professional training, not only in updating of education for psychologists and social workers from a rehabilitation perspective, but the generation of new professionals of equal status who can function in the field rather than in the formal centres which have become the basis of our literally concrete service. The future can involve a much more flexible model of service and such a process should be developed within the very near future. The problems of transfer of training, of leisure time activity, and of adequate employability, must be overcome if parents are going to cope with looking after their own handicapped youngster. It is imperative that much more of a field model of rehabilitation be developed. This represents a major challenge to the existing training centres, to special education classes, to the role of educators in the formal sense of teachers and training supervisors, and to the existing professions, particularly social work and psychology. Whether the above represents future trends in the United Kingdom or elsewhere depends on the flexibility, as well as the motivation, of those who are currently in the field, and whether they are willing to rise to the challenge of rejuvenating services to handicapped people on a widespread basis.

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Quigley, S.P. & Paul, P.V. (1984) Language and Deafness

Croom Helm

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This book is aimed at teachers of the deaf and clinicians concerned with the placement and education of a particular group of hearing-impaired children. It draws on a vast amount of research in communication methods, language, cognition, reading and writing, bilingualism and English as a second language. Most of the research is American and, therefore, evidence and conclusions must be considered within the American educational system for the hearing-impaired. They cannot be transferred wholesale to the British scene.

Nevertheless, the book should be of interest to British teachers of the deaf for its wealth of research and its contribution to the debate on communication methods. The authors do not oversimplify the issues and are careful to present conflicting evidence, where this is found. They do not hesitate to draw their own conclusions.

They begin by defining what they mean by deafness. "Basically, for the purposes of this book, a child is considered deaf if hearing impairment is so great, even with good amplification, that vision becomes the child's main link to the world and channel of communication..... the shift from audition to vision as the main channel of communication occurs at about 90dB for many children."

One may not agree with this definition, but it is essential that a clear distinction should be made between those who are able to develop aurally and orally and the small group who cannot. The authors lament the fact that so much of the research they examined does not define deafness. One might prefer that a cut-off threshold was not stated lest it become self-fulfilling for all children with hearing losses greater than 90dB. On the other hand, it is heartening to note that they expect children with losses between 70dB and 90dB to function aurally and deplore the widespread use of combined methods of communication with this group in the U.S. public schools.

The authors are emphatic that language cannot be considered separately from modes of communication. They give useful definitions and the American backgrounds of the various modes: Oral English, Manually Coded English, Pidgin Signed English and American Sign Language. They regard Oral English as the best method, if it is possible. Some British teachers who are successfully teaching with natural aural/oral methods might be startled to learn that structured English teaching is considered

necessary. For the benefit of British readers it is worth noting the difference in terminology. In the U.K. oralism usually includes speech reading. Quigley and Paul refer to this as the aural/oral method, whereas in the U.K. aural/oral is taken to mean what the authors call the acoupedic or unisensory method, (ie, minimising the role of speech reading and maximising residual hearing).

The authors note that the history of deaf education in the U.S.A. has been subject to wholesale swings of fashion in methods, followed by disillusionment, and regret that changes were not made more cautiously and with careful monitoring of progress. They feel that there is no single 'right' method for the deaf.

Manually coded English, as part of Total Communication, has been widely used in American public schools for the past 10-15 years and is gaining ground in this country. Quigley and Paul quote research evidence which shows that combined aural/manual methods have made no difference to the achievement levels of the deaf in language, reading and writing. They cite research which shows that even the most skilled oral/manual teachers cannot achieve simultaneous communication in both modes. Via one or both channels ungrammatical messages are relayed to the child, who already has a difficult enough task in learning language. "It may be desirable to use but a single channel to reduce cross-channel interference" (Nix 1983). They agree with other workers that manually coded English degenerates into Pidgin signed English, and conclude that only two methods should be considered - wholly aural/oral or wholly manual.

Their conclusion that for some deaf children a wholly manual method of communication, American Sign Language, should be adopted, is a logical one to reach in the light of the evidence they have cited. However, they do not point out that there is a surprising dearth of research into the achievements of deaf school leavers. The only large-scale study was of 600 school leavers from three private oral schools. The achievements of these ex-pupils was "impressive". Nothing similar has been done on pupils educated by combined methods.

American Sign Language (ASL) is considered to be a true language with its own structure and vocabulary. It has been extensively studied as a language in recent years. However, ASL is not used systematically in education but exists within the deaf community. The authors insist that any move to educate via ASL should be very carefully monitored and should begin with deaf children of deaf ASL-using parents.

Although they advocate this wholly manual method for some children within their definition of deafness, they are careful to point out the drawbacks. One major area of difficulty will be reading. They devote an entire chapter to research findings on reading by both hearing and deaf children. It seems that when reading one recodes the written pattern into speech and this is

retained in short-term memory in order to comprehend the whole. Even deaf children whose speech is unintelligible have been found to recode into speech. As is well known, reading levels attained by many hearing-imparied are very low and have not risen over the years despite all the research into their language. Teaching reading assumes certain levels of linguistic competence, inferential skills and figurative knowledge as well as general knowledge about the world. Many deaf children do not reach these levels before they learn to read. The problem would be compounded for children whose first language is ASL with its own structure. The authors make two suggestions; that such children do not learn to read at all but could perhaps learn via-video-tapes of signs; that research into alternative methods of teaching reading should be undertaken. They suggest starting with those deaf children of deaf parents who are known to be higher achievers to see how they learn to read. It is assumed that they have succeeded because they have been brought up using manual methods of communication. But, as the authors point out, there is no evidence for this assumption. Some deaf parents are oral. Other factors, such as the emotional environment, and the ready acceptance of the handicap in a hearing-impaired home might be equally effective. Time and again the authors state the importance of the parents.

Parents are the second problem if children are to be taught manually. Hearing parents cannot be fluent signers, they would have to learn with their child. "Parents of deaf children fail to develop even an average proficiency, at least during the important early developmental period, in the use of manually coded English and sim-com (simultaneous communication)" (Nix 1983). This is another reason why the experiment to teach children via ASL should be confined at first to deaf children of deaf ASL-using parents.

The authors looked at the growing body of American research into bilingualism and English as a second language (ESL). They advocate that those children taught ASL as a first language should learn English as a second. This would need to be manually coded, for the reasons already stated and because such children would not have learned to use effectively their residual hearing during the vital early years. What the authors do not say is that such children would probably be dumb. This is a disturbing thought for any teacher whose aim is to normalize as far as possible.

The greatest omission in the book is reference to residual hearing. Perhaps in the light of their conclusion to advocate ASL for the children they define as deaf, the almost total silence about audition is understandable, but is surprising to British teachers who consider audition subsumes education of the deaf. The British teacher is expected to be expert in audiology as well as speech and language. One could venture to suggest that the distinction between the roles of the teacher and the audiologist in the U.S.A. has contributed to the almost wholesale use of combined methods in U.S. public schools, leaving

aural/oral methods to the private schools. This is sad, particularly in view of the U.S. findings of the "impressive achievements" of the orally-taught deaf school leavers from private schools. The authors imply that these results were due not so much to the method of communication but to I.Q., socio-economic status and parental interest. However, experience in this country shows that I.Q. and socio-economic status are not factors, whilst parental interest most likely is. Huntington and Watton (1984a,b) found profoundly deaf children with losses greater than Quigley's and Paul's cut-off point were learning and using natural language which was almost on a par with that of their hearing peers. These children were found in some state special and mainstream schools.

Quigley and Paul correctly point out that all methods of communication have been tried over the past 400 years and none of them has proved to be wholly successful. "....most of the present approaches (with the exception of such relatively recent technological advances as amplification) have very long histories." The authors seem to be dismissing amplification, which is the cornerstone of the aural/oral method. Improvements in amplification are so great and are advancing so rapidly that I feel that no hearing-impaired child without any other obvious disabilities no matter how deaf, should be denied the opportunity to learn to use residual hearing. The young hearing-impaired children of today, who have the benefit of radio hearing aids which adequately reach beyond their thresholds will be far more successful in their use of speech and language than will those leaving the schools at the present moment. There is a lot of sense and logic in the authors' arguments for either an oral or a manual approach, but I, for one, would not care to make the decision which will effectively cut-off a deaf child from being a part of the general community. He may choose to become part of a deaf, signing community, but he should have the opportunity to make the choice himself and not have it made for him.

We, on both sides of the Atlantic, can, perhaps, learn from the Dutch experience. At St. Michelsgestel all children are given the opportunity to start aurally (unless there is some obvious factor which would make this impossible). The children are very carefully monitored and tested before a decision is made to place them in the manual school. So often in this country the child has to fit the system pertaining in his school, although Statements should prevent this in future. The American idea of individualized teaching programmes must fall down when, as implied by the authors, teachers are using different modes of communication with different children. They do not mention whether it is the practice to separate the manual from the oral communicators. If not, the children will have the worst of both worlds. However, this may be reading too much into their statement that all teachers of the deaf should be proficient in all methods of communication and be able to teach English in a natural or structured way or ASL, as required by the children's programmes.

Quigley and Paul have not come to their conclusion lightly. They have looked at a great deal of evidence of research in the U.S.A., and their conclusion may be the correct one for that country where there is a large deaf population. Their book is certainly stimulating. It is easy to read, concise, coherent and well laid out with clear headings, sub-headings and summaries and conclusions at the end of every chapter. My only quarrel is with their predilection for introducing initials into the text. It took a few seconds of working backwards to work out that DCDP and DCHP stood for deaf children of deaf parents and deaf children of hearing parents.

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